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ABSTRACT

This survey was conducted to provide informational inputs for planning and establishing a community health education system in southwest New Mexico. Information was gathered concerning the opinions of typical area residents regarding needed health-medical care facilities, personnel training needs, services, personnel requisite to their well-being, and needed preferred health education. A modified random sample of households was selected according to rural and urban strata, and 400 personal interviews were conducted. Survey results included a reported need for more health/education training among 59 percent of the respondents. General household health care and emergency first aid were selected most frequently as preferred topics. Television and radio and adult education courses received the highest number of responses as preferred means of learning. Subjects also expressed concern about needs in the areas of increased manpower, physician-client relationship, improved physician service, cost of health care and services, facilities improvement, and diagnostic/preventive service manpower and education. (Author/DS)

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Report of a RESIDENT HEALTH-MEDICAL CARE SURVEY

SOUTHWEST NEW MEXICO
COMMUNITY HEALTH EDUCATION SYSTEMS

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Prepared by:

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Prepared for:

New Mexico Regional Medical Program and
New Mexico State University Cooperating

June, 1973

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NOTE

The New Mexico Community Health Education Systems program was funded through the New Mexico Regional Medical Program July 1, 1972. In the Southwestern consortium, December 16, 1972, New Mexico State University, and its College of Education, Educational Research Center as the subcontractor for performing certain tasks, entered into an agreement with the Regents of the University of New Mexico and the New Mexico Regional Medical Program.

A position search was conducted for the Southwestern CHESS Coordinator by representatives of a Southwestern Consortium steering committee. The successful candidate, Mr. Roger Poulsen, a doctoral student in Educational Administration and the Educational Research Center, New Mexico State University, assumed the half time duties of Southwestern CHESS Coordinator, and Project Director, January 2, 1973. Prior to his selection, a CHESS steering committee had been organized in the consortium and certain meetings held for the purpose of general planning, discussion , and specification of Coordinator employment search procedures.

The Southwestern CHESS contract included a provision for project and coordinator renewal and continuation subject to mutual agreement among parties to the contract, and continued federal funding of Regional Medical Programs after June 30, 1973.

President Nixon, in his budget address of January 29, 1973, recommended that federal funding of Regional Medical Programs be discontinued and that these programs cease to exist throughout the nation by June 30, 1973. In some instances, Regional Medical Programs and their subsidiaries have either ceased to exist, have continued operation on a drastically reduced manpower basis, or have continued operation through assimilation into existing government agencies or assumption of economic support by state, local, and/or private sources.

The Southwestern CHESS project, prior to the Presidential budget address was a developmental multi-stage project involving 28 months as outlined by NMRMP. A primary task of the consortium, a health-medical care needs survey, finished report in multiple copies, was scheduled for completion date of end, August, 1973, by verbal agreement between the New Mexico State CHESS Coordinator and New Mexico State University. However, requirements for NMRMP and Southwestern CHESS phaseout, required alteration of this scheduling to a June 30, 1973 survey completion date.

From January 2, 1973 through May 11, 1973, Mr. Poulsen fulfilled the obligations of graduate student and half time Southwestern CHESS Coordinator, with a theoretical CHESS project obligation of twenty hours per week. Since May 14, 1973, Mr. Poulsen has assumed a full time CHESS role until June 30, 1973.

During the period January 2, 1973 to June 30, 1973 planning and implementation of the Southwestern Consortium tasks of conducting a reported health-medical care needs survey, and establishing a framework for a working CHESS, have proceeded in spite of national changes concerning state Regional Medical Programs. Work was conducted, and has proceeded to the extent possible, as if the Southwestern Community Health Education System will further develop its existence into a viable, ongoing, local organization, concerned with community health education and health manpower training at the local level.

In the knowledge of the writer, a final determination of Regional Medical Program status throughout the country, and in New Mexico, is pending. At this time, according to the most recent NMRMP Southwestern consortium memo from Mr. Gar Elison, Executive Administrator, the Southwestern CHESS project will terminate June 30, 1973.

ACKNOWLEDGEMENTS

This report, and the extensive work completed as its base, is a cooperative endeavor. The Southwestern CHESS Steering Committee has served as an acknowledged resource. The Chairman of the committee, Dr. Lowery Davis, Dean of Continuing Education, New Mexico State University, and acting secretary, Dr. Darrell Willey, Associate Director Educational Research Center, New Mexico State University, have provided guidance and leadership for direction. Various university resource individuals, such as Dr. Timothy Pettibone, Head, Department of Educational Administration, graciously offered their services and other consultants have ably contributed their expertise. Logistical support for a project of this type, including processing and typing, is a necessary and appreciated function.

A special note of thanks is due to the four hundred New Mexico residents who enthusiastically offered their time for providing their household health-medical care information. Also, mention is made of the required bilingual interviewer skills and the difficult task of completing personal interviews in remote rural and varying urban situations. Mr. Carlos Chavez, El Paso, Texas, served as a full time interviewer. A graduate of the University of Texas at El Paso, his past experience included survey training and experience in the field of venereal disease prevention, U. S. Public Health Service Communicable Disease Center, Atlanta, Georgia. Mrs. Edith Escobar, El Paso, Texas, completed extensive and thorough interviewer training as a full time interviewer. She had previously assumed various positions of business responsibility including ownership of her own successful pet store in California. In her role, she continually exhibited perseverance and enthusiasm.

I

SURVEY REPORT SUMMARY

As a result of an agreement between New Mexico State University and the New Mexico Regional Medical Program, a Community Health Education System survey was conducted in a consortium of eight Southwestern New Mexico counties (Catron, Dona Ana, Grant, Hidalgo, Luna, Sierra, Socorro, Otero), March-April, 1973, concerning selected dimensions of health-medical care. The purpose of the survey was to provide informational inputs for planning and establishing a CHESS framework in the southwest quadrant of the state. Liaison with the El Paso, Texas office of the Texas Regional Medical Program was established and maintained.

The problem was to obtain information and opinions of typical area residents concerning their descriptions of needed health medical care facilities, personnel training needs, services, personnel requisite to their well being, and needed preferred health education.

The concept of a CHESS involves a community based health education and manpower development system. Its goal is to enable both health care consumers and providers to assess and evaluate their own health education, manpower, and training needs, and to assume a major role in ensuring that these needs are met.

A modified random sample of households was selected according to rural and urban strata. Four hundred personal interviews were completed by two full time trained interviewers using a bilingual personal interview guide.

Considerations for analysis and presentation of results included practical limitations and requirements of the state CHESS Coordinator. A combination of descriptive analysis (frequency and percentage) and the chi square statistic was used. The latter for testing four null hypotheses concerning the reported household satisfaction with health/services care received in relation to the variables of annual household income, head of household's education, head of household's ethnic group, and residence location.

Survey results included a reported need for more health/education training among 59% of the respondents. General household health care and emergency first aid were selected most frequently as preferred topics. Television and radio and adult education courses received the highest number of responses as preferred means of learning. In addition, among respondents interviewed in the sample, certain themes of overall recurrent needs were identified. These needs concerned the subject areas of increased manpower, physician-client relationship, improved

physician service, cost of health care and services, facilities improvement, and diagnostic/preventative services manpower and education.

Conclusions pertained to identified needs from the survey results and recommended proposal topics. Suggestions for proposal topics included the new health-medical care personnel categories of subintern and consumer/professional health liaison/program development specialist. These two categories would help meet personnel and manpower training needs. Also increased emphasis upon social and behavioral science information and training was suggested for integration into various professional health education curriculums.

Proposal topics for meeting identified health services needs include: feasibility of a joint venture between the University of New Mexico Medical Center and the New Mexico State University Cooperative Extension Service for the purpose of providing an educational health information program; use of selected service organizations such as senior level explorer scouts, Boy Scouts of America, for use in public preventative innoculation programs; investigation of a telephone information service, "Tel-Med" for public health education.

A proposal relating to facilities needs suggested continued identification of local resources such as the newly approved Continuing Education branch of New Mexico State University, servicing the Southwest consortium. Primarily contingent upon need and funding, such a source might eventually be utilized for health education, training of personnel such as dental technicians, and continuing education for professional allied health personnel.

II

INTRODUCTION

Regional Medical Programs were created in 1965, under the funding provisions of Title IX, a 1965 amendment to the Public Health Services Act (Public Law 89-239), which authorized grants to assist in planning, establishing and operating regional medical programs to combat heart disease, cancer, stroke, and related diseases. Since their inception, the purpose of regional medical programs has expanded in scope. Among the charges of these programs were "affording the medical profession and the medical institutions of the nation . . . the opportunity of making available to their patients the latest advances in the diagnosis and treatment of diseases" and "improving generally the health manpower and facilities available to the nation."[69]

A statement of the health resources in a particular area, and health care delivery, necessarily includes health care service providers and consumers. Some previous information exists concerning health providers and their resources including the Southwestern consortium (see New Mexico Regional Medical Program, NMRMP, Physician and Osteopath Continuing Education Survey; Nursing Service Survey; and Community Hospital Administration Survey; New Mexico Health Occupations Program Directory).[73] However, little or no information concerning the health care consumer exists for the Southwestern consortium. To this end, it was desirable to identify the range and kinds of descriptions of the general public regarding selected aspects of their health-medical care experience. These included location and usage of services and facilities available to them, household financial protection and health assessment, attitudes expressed about health and medical care topics such as education, evaluation, and expressed desire for additional and more effective services, facilities, educational information, and consumer background variables.

IIA

CONCEPT OF COMMUNITY HEALTH EDUCATION SYSTEMS

The central focus of CHESS, and the survey, is community health education. A CHESS, when operational, is intended to be a community-based manpower development system. Its goal is to enable both consumers and providers to assess and evaluate their own health manpower and training needs and to assume a major role in ensuring that these needs are met. This system will hopefully provide planning assistance for development and training of additional manpower and continuing education for health personnel and the general public.71,73

The Community Health Education Systems program in New Mexico is divided geographically into four quadrants as outlined by the New Mexico Regional Medical Program. The quadrants are the southeast, northeast, southwest, and northwest. Each quadrant is a consortium of counties. The Southwestern consortium includes a total of eight counties. They are Catron, Dona Ana, Grant, Hidalgo, Luna, Otero, Sierra, and Socorro. The use of a consortium arrangement, as specified by the Regional Medical Program, derived from previous experience with New Mexico education and manpower development programs. Previously these programs were primarily satellites of the larger institutions of higher education in the state. As such, programs were "not readily accessible to many individuals, required lengthy periods of travel time, were reportedly less effective than if taught at the local community level, and were mostly characterized as inflexible and non-adaptive to local needs of small communities."70,71

The CHESS system will be community-based and locally controlled. To this end, the quadrant division of the state of New Mexico facilitates local control. The New Mexico Regional Medical Program (NMRMP) concept of CHESS involves local conduct of programs based on expressed needs of local people in small and large communities, rural and urban areas. An advisory committee would govern the CHESS program in each quadrant. Such a committee would be comprised of interested lay individuals, educators, health/medical care professionals, and Regional Medical Program CHESS staff members. This group would work with each community and residents within the consortium to identify their needs. These could include "manpower, education, patient care improvement, monitoring cost effectiveness, or achieving better cost benefit ratios."69,71 Future communication and coordination among CHESS quadrants is anticipated by representatives selected from each advisory group. A CHESS could be legally incorporated so that it can present program proposals and contract for programs and services.

Educational programs to be undertaken would include those needed in each consortium to fulfill reported needs of individuals, develop additional health manpower, or to upgrade skills of existing manpower functioning within a consortium. Educational programs could be provided for the public and allied health care professionals through use of existing educational and health care facilities within the quadrant.[73]

The following Southern Consortium developmental steps are mentioned as outlined by the New Mexico Regional Medical Program according to time and events:

1.	Develop body	8 months
2.	Hire personnel	2 months
3.	Priority needs	6 months
4.	Local resources available to meet needs	3 months
5.	Outside resources required to meet needs	3 months
6.	Location of programs, facilities, number of people needing training	2 months
7.	Write grants, place grants and obtain funds to continue operational phase	4 months

The Southwestern CHESS is assigned a priority of three among the four state quadrants by the New Mexico RMP. This is because no comprehensive health planning or other health planning body is operating in this geographical area. Only exploratory interest has been displayed in establishing a CHESS. However, there are numerous resources available including health professionals, educational institutions, and lay individuals. Some limited indication of interest has been expressed among these sources. The possibility for potential interstate coordination of health education activities between Southern New Mexico and West Texas has been recognized and acknowledged through liaison with the Texas Regional Medical Program Office in El Paso, Texas.[71]

A primary emphasis of the Southwestern Community Health Education System, as specified by the New Mexico State CHESS coordinator, is the concept of educational programs for the lay public and health professionals. The State CHESS Coordinator, and the NMRMP, specified the desired role of resident participation in the Southwest quadrant. It was verbally stated that no one individual or special interest group should determine the health-medical care needs of an area based on their own preconceived ideas or special interests. Rather, a developmental task type concept would be utilized to provide citizenry a meaningul opportunity for involvement and participation in planning, establishing, and evaluating program goals. This method is one alternative providing for self development and encouraging local inputs and positive reinforcement. Minimal interference and guidance from "outside sources" is seen as assisting interested individuals in a local area to realize and extend their potential capabilities.

SURVEY PURPOSE, PROBLEM, AND OBJECTIVES

The primary purpose of this survey was to provide informational inputs to assist in planning for and establishing a Community Health Education System in the Southwestern consortium of New Mexico. This compilation of health-medical care needs is one developmental step in a 12-28 month planning cycle outlined by the New Mexico Regional Medical Program in their "Proposal for Development of Statewide Community Health Education Systems (CHESS) in New Mexico, Southwestern Consortium." Completion of the total cycle of seven developmental steps would enable the Regents of the University of New Mexico, through New Mexico Regional Medical Program and New Mexico State University, to plan and develop the Southwestern Community Health Education Systems.

Additionally, the CHESS health-medical care needs survey provides a limited data base of resident information. This input serves as one important basis for planning and establishing a southwestern CHESS framework. To this end, in view of the lack of other existing definitive health-medical care information for the area, the survey results provide consumer information concerning health care needs against which goals and programs may be established, progress evaluated, and follow-up provided for. Although not viewed as the central purpose, this pilot survey could be used as a directional model for future research and establishment of a cumulative data base in the southwestern consortium.

The problem as stated was "to conduct a survey or surveys of those eight counties in southern New Mexico and El Paso, as to opinions of typical citizenry regarding their description(s) of needed health-medical care facilities, personnel training needs, services, and personnel requisite to their well being." Verbal directions from the New Mexico State CHESS Coordinator, and contract provisions, indicated a desire to obtain as much meaningful information as possible about "health-medical care needs, community health education and inputs for manpower training."

The objectives of the survey included focus on and determination of information relative to select medical-health care problematic variables and certain of their dimensions. These included location and usage of services and facilities available to them, household financial protection and health assessment, attitudes expressed about health and medical care topics such as education, evaluation and expressed desire for additional and more effective services, facilities, educational information, and consumer background variables. One important source used to fulfill the NMRMP request, and provide health-medical care educational inputs, was a classification and determination of health services/facilities utilization. By inference, such information indicates needs for health manpower and health education planning.

THEORIES AND CONCEPTS OF ILLNESS

A determination of needed health-medical care facilities, additional personnel, services, and personnel training, is interrelated with and dependent upon the causal concept of illness. Establishment and clarification of potential physiological, psychological, and sociological elements in the illness-treatment experience facilitates understanding of the health-medical care situation, illustrates the range and complexity of numerous variables in the health-medical care situation, and provides a logical and systematic cognitive approach for isolating variables and information to be obtained through descriptive measurement.

There are varying interpretations and explanatory models concerning the nature of illness. One simplistic view defines illness as any state diagnosed as such by a competent professional. A second definition emphasizes the importance of the patient's perception. That is a person who states that they are ill should be regarded as such.[11]

Various explanatory models attempt to clarify the nature of illness and specify its cognitive and action elements. The epidemiological model maintains that illness results from contact between a noxious agent and tissue, thus producing a morbid change. King's stress related model incorporates the interaction processes among genetic predispositions, exogenous and endogenous physical agents, and stress coping mechanisms which may result in the onset or avoidance of disease.[11]

Parson's sociological view of illness is theoretically popular but is has received limited use by empirical investigators. Parsons states that a person's illness needs to be legitimized by authority of the medical profession, intimates, or other persons having influence over the individual. Once the legitimation is received, the person assumes a sick role which modifies or replaces his usual occupational or familial roles. Assumption of the sick role enables avoidance of obligatory duties but enables him to impose norms on family, people near by, and attending physicians.[53]

Other sociological theories of illness include work by King emphasizing perceptual components in illness. The crucial variable is represented as each individual's perception of the disease situation and accompanying social ramifications.[11] Mechanic's concept of illness behavior focuses on the way in which given symptoms may be differentially perceived, evaluated, and acted upon.[46] Another theory, proposed by Suchman, discerns five identifiable stages in the illness process separating critical transition and decision making points in medical care and behavior. The stages are symptom experience, assumption of

the sick role, medical care contact, dependent-patient role, and recovery or rehabilitation.[7] Kasl and Cobb distinguish among health behavior, illness behavior, and sick role behavior. They reason that the probability that an individual will participate in and exhibit a particular kind of health, illness, or sick role behavior depends upon two variables: the perceived extent of threat and the attractiveness or value of the behavior.[11]

The concept of a morbid episode as an explanation of illness is offered by Kosa and Robertson. This view maintains that such an act or condition must be an interruption of the normal or desired course of events because normal or desired states are free from such episodes. The extent of illness present in any situation is determined by the assessment of patients, laymen, and other professional personnel.[11]

What a layman perceives is a comparative difference between the present (acute) functioning of health and its previous or usual functioning. This felt difference is communicated in terms of symptoms which offer inexact clues to the disturbance. Symptoms usually cannot be quantified by the layman, so laymen frequently use subjective criteria in judging whether an observed phenomenon should be assessed as a symptom. Criteria vary dependent upon situation variables. This assessment initiates a social-psychological process of handling the morbid episode which is a part of the usual pattern of social interactions. Four elements of the process are: assessment of disturbance or threat to usual functioning of physiological and psychological health; arousal of anxiety by perception of such an incident; application of ones' general medical knowledge to a given disturbance; and performance of manipulative actions for removing the anxiety and disturbance. From this theory it follows that the health behavior of people seems to be governed by belief in a desired state of health rather than by the teaching of biological sciences.[11]

From the patient's point of view, the four elements are interrelated. Existing medical knowledge rationally functions as a censor of anxiety and modifies perception and manipulation. In turn, this knowledge is modified by experience gained in each morbid episode. The patient, although the center of the episode, needs the assistance of family and those in his immediate environment.[11]

Szasz mentions that many common-health related actions and experiences cannot be clearly established as illness or health. The dichotomy of illness and health precludes preventive measures common among various individuals. These include activities such as daily exercise, diets, or check-up with physicians. Also an either or classification does not provide for the inclusion of small incidents of life (abrasions, lacerations, common colds, flu, etc.) which temporarily upset routines but are of a minor nature and short duration. Also a dichotomy does not

accomodate many common forms of disability which are compensated, rehabilitated or corrected naturally, with professional help, or by wearing eyeglasses, dentures, protheses, or tooth fillings. Moreover, complaints ranging from the psychosomatic component of every illness to nonincapacitating and not-treated but serious psychoneuroses are excluded. Nevertheless, the aforementioned cannot be ignored for their importance and associated health-medical care implications.[11]

II D

IMPORTANCE OF THE CONSUMER IN RELATION TO SELECTED TYPOLOGIES OF HEALTH CARE RELATED PROCESSES

The New Mexico State CHESS Coordinator emphasized the importance of the consumer segment in the operating philosophy of the New Mexico Regional Medical Program. The following hypothetical framework is a generalization depicting varying conceptual and action orientations, not infrequently excluding or deemphasizing consumers, among selected typologies of health related processes. The complex of interrelated variables in the client segment is functionally and differentially related to other manpower category orientations in the health care planning and delivery process.

It is apparent that the consumer segment represents a numerically large and socially/politically powerful source of influence in health care planning. Moreover, certain health related manpower typologies have recognized the importance and potential use of consumers. Accordingly, they have reoriented and readapted their organizational strategies to include consumer inputs as a necessary and desirable resource for planning.

SURVEY

HEALTH/MEDICAL CARE PROCESS CONCEPTUALIZATION AND ACTION ORIENTATION FRAMEWORK IN RELATION TO CLIENT NEED CONSTRUCT*

(Continued on following page)

SERVICE SUPPLIERS**

Elements in Conceptual Orientation

Professionals/paraprofessionals

University degree and/or training certificate

Expertise, experience referents 81

Exclusivity and the professional ethic ("eminent domain" versus logical overlap of services) 30, 31, 43

Social distance and hierarchial relationship, role concepts (provider versus "providee" – in need of services) 11, 30, 31, 81

Professional organizations and associations function in role establishment and reinforcement 30, 33, 31, 81

Legislative and statutory restrictions

Elements in Action Orientation

Expand job role

Increase numbers

Client need tokenism

1. Limited inclusion of client-centered courses in training programs and curriculums 31
2. Client considered logistically in terms of workload, economic aspects, delimiting of numbers and types of patients 31

Less emphasis on ratio of expenditure to quality of return evaluation

Reliance on government and association supportive and baseline data for collective planning and guides

Political and economic power structure orientation at local and higher operational levels 24, 33

GOVERNMENT AND ORGANIZATIONAL PROGRAM PLANNERS/ FACILITIES, INDUSTRIAL DEVELOPERS OF EQUIPMENT, DIAGNOSTIC TECHNOLOGY AND PHARMACEUTICALS**

Elements in Conceptual Orientation

Secondary data approach (mortality, morbidity etiological and incidence of illness statistics as important inputs for planning) 86

Management cost analysis approach of optimizing return on investment with given numbers of services, facilities, patients 31, 62

Homeostatic approach (a collective arithmetic balance of individuals in relation to facilities, services, and technological capabilities) 62, 86

Dollar volume and potential market share based on manufacturing and marketing capabilities 62

Elements in Action Orientation

Statistical and numerical approach to individuals in a collective orientation 86

Tokenism client approach – incorporating client social science oriented material on trial-experimental basis or as limited portions fit into the central plan. 11

Planning in terms of modifying facilities, products, before determination of attitudes for directional change inputs 18

Increase number of facilities and kinds of services available or expand existing structures, programs 62

Abandon existing facilities, programs, products, resulting in temporary or permanent void

Applied research and development activities according to priorities of probable commercial application and projected profitability (primary ethic of free enterprise system is the profit motive) 62

Establish product differentiation and compete to provide most advanced technology

Governmental reliance on bureaucratic structure and political strictures

Industrial emphasis on role, status hierarchy, formal and informal social and power structures, economic system

* Number of elements involved, stages and development vary in sequence and priority according to individuals involved and situational variables.

** No implication is intended concerning across the board application—this chart is a generalization for purposes of illustration—the extent to which exceptions and differences in New Mexico exist are a function of numerous variables, both controlled and uncontrolled.

SURVEY

HEALTH/MEDICAL CARE PROCESS CONCEPTUALIZATION AND ACTION ORIENTATION FRAMEWORK IN RELATION TO CLIENT NEED CONSTRUCT *

(Continued on following page)

SALES[1] AND DISTRIBUTION INFORMATION SOURCES ** (Alternative sales and distribution information sources are interrelated to and reinforce conceptual and action orientation of service, suppliers, planners, facilities, industrial developers)

	Sources:	Limited emphasis on:
Public and Private Efforts	Health education, Dental education, Optical education (current emphasis promotes exclusiveness—subject matter only for those in the "fraternity"—job protection, "help public help themselves" to a limited extent)	Extensive integration into existing public and private education, foundations, government experimental and pilot programs, expanded use of mass media for practical education (information dissemination), role of socialization process in attitude development
	Specialist boards/professional-government-industrial liaison	Apply newest techniques, more government-industry awareness and cooperation in research and development
	Professional organizations and associations	Innovative programs and leadership, specialization promoted to restrict lay participation and role reorientation [33]
	Hospitals, clinics, health care centers [43] Out patient mobile delivery Out patient static facilities	
	Cost planning-medical insurance	Across the board Medicare, Medicaid coverage, group insurance for employers
	Sale and distribution of services, products through existing economic and market structures directed toward middle class needs (existing or created)[11]	Determination of need versus creation of need and repeat purchase (profit motive) Inflexible market structure for numerically small population segments [62]
	Word of mouth (formal and informal, direct and indirect) and primary (peer group) and secondary associations) [34]	Information divergent or inconsistent with perceived norms, values, and roles of the individual in relation to information referent and source [11, 13]
	Recorded source information—private and public (medical and health care abstracts, clinical/professional studies, health care data banks, journals, Food and Drug Administration) IND – investigatory new drug and NDA – new drug applications	Availability, distribution emphasis, interest, and terminology reinforces role specialization and exclusiveness [35]
	Legal and legislative	Change and innovation; and individual responsiveness versus interest groups [43]
	Political	Practical orientation motivated by power structure role/status expectations [18, 40, 43]
	Medical, dental, optometric, osteopathic, chiropractic, nursing schools [43]	Client-centered knowledge (primary emphasis disease knowledge) [18]

[1] Sales refers to favorable image information concerning existence and provision of a service, facility, and/or program implying positive role performance and preferred use in contrast to other alternatives.

CLIENT/CONSUMER/PATIENT[1]

Elements in Conceptual Orientation

Physiological, psychological, and sociological components are the primary determinants of behavior [13, 47, 49]

Except for startle responses, and certain psychomotor reflexes, behavioral predisposition is determined primarily by attitudinal components (cognitive, evaluative, affective, action) [11]

Goal oriented health and medical care behavior in terms of individual perception, definition, and conceptualization of health/medical care, illness, and the health care-disease process [2, 11, 52]

The influence of role, status, class structure in relation to perceived behavioral norms and sanctions [2, 5, 16, 30, 31]

Elements in Action Orientation

Varies according to individual social psychological field and differential exposure to socialization process (cultural and societal) [13, 30, 32, 58]

Behavioral unit acts as an extension of individual perception, definition and conceptualization of health/medical care, and health care-disease process, in relation to intervening environmental variables (access, distance, availability) [13]

Awareness, knowledge, attitudes, acceptance, and use of health/medical care information as influenced by the complex interrelationship of individual, cultural, and societal variables [11, 13, 31, 43, 65]

[1]Occassionally client knowledge, and use of this information, is the last stage in a planning process. In other instances, it may be considered early in planning but to a limited extent.

II E

SURVEY FRAMEWORK VARIABLES

It was necessary to selectively determine what conceptual elements to include in the survey, what information they would provide, and their usefulness and congruence with the nature of CHESS. Examination of other state CHESS survey reports revealed information obtained without specification of variables or hypotheses. However, considerable attention was directed toward the problem phase and specification of variables as the first and most important step in the research process. Although the survey was more akin to an information inventory rather than an empirical study, this procedure was used in planning for what should be included, organizing, and providing for meaningful analysis. A review of the literature which follows, and the importance of the health-medical care consumer role, provided the organizational basis for the survey's conceptual framework.

Within the past two decades, a surge in national and international research has occurred concerning the topic of health-medical care and its various dimensions. The impetus for this increase in research activity has come from many sources. Among these are an expressed national commitment for more equitable distribution of health care and services for all people, and adaptive and pioneering modes of health care delivery.[4]

Perusal of the literature reveals differences in variables considered, variety in measures employed by researchers, populations observed, sampling procedures, and dissimilar analyses. Accordingly, conclusions and establishment of national trends have in some instances been derived from studies which need further replication.

As a result, findings concerning certain topics included in the literature, such as health services, are sometimes in disarray, unclear, and/or in conflict with other information. Also, differences in research purpose, design, and analysis among studies determine varying specification of independent and dependent variables and demonstrated effects and interrelationships among these variables.

Studies concerning results of health-medical care educational programs (curriculum alternatives, use, and evaluation results) and training for the lay public, professionals, and paraprofessionals, are limited in number and, to my knowledge, are virtually nonexistent for Southern New Mexico. In other instances, studies are limited in generalizability by their research design and/or local and provincial concerns and characteristics.

In conceptualizing the survey and determining its scope, it was necessary to specify and classify relevant health-medical care variables for purposes of planning. Consideration of a classificatory scheme for variables facilitated planning for accomplishment of the primary survey objective of obtaining perceived health-medical care information as reported by residents. Second, as an additional survey information spinoff, four independent variables (head of household's education, household income, head of household's ethnic group, and household rural or urban location), were considered. A determination was sought as to whether or not there were significant variations in reported household satisfaction with health services/care received (dependent variable) as affected by differences within four independent variables, each analyzed separately. The four independent variables were: household income (two categories); educational levels of heads of households (two categories); ethnic background of heads of households (Anglos and Mexican-Americans); residence location (rural or urban).

A review of the literature reveals specification and classification of consumer and health-medical care utilization variables and correlates, consideration of indices used for measuring, and, methods for determining significant predictors of each.

Variables and correlates included in results from most empirical studies can be categorized according to the following integrated models of Aday, Eichhorn, Andersen, and Anderson:[4]

I. PREDISPOSING VARIABLES

- A. Socio-Demographic Correlates
  - 1. Age
  - 2. Sex
  - 3. Education
  - 4. Marital status
  - 5. Family size and composition
  - 6. Race or ethnicity
  - 7. Religious preference
- B. Social-Psychological Correlates
  - 1. General health care attitudes
    - a. health beliefs and medical orientation
    - b. perceived availability of care
    - c. tendency to use services (physician,etc.)
    - d. skepticism of medical care and services (physicians, etc.)
  - 2. Knowledge and sources of health care information
  - 3. Situation-specific stresses
    - a. perceived susceptibility
    - b. perceived seriousness
    - c. perceived chance of recovery
    - d. psychological readiness
  - 4. Generalized stresses
    - a. psychological
      - (1) upsetting events, crises, chronic stresses
      - (2) fear, worry, anxiety, etc.

b. structural
(1) social isolation-powerlessness, anomie
(2) broken or intact family
5. Patient-physician interaction
C. Previous Health Behavior

II. ENABLING VARIABLES

A. Economic Correlates
1. Socio-economic status and occupation
2. Income
3. Price of medical services
4. Methods of financing
a. third-party payors
(1) voluntary insurance
(2) Medicare, Medicaid, welfare
b. type of coverage-idemnity, Blue Cross-Blue Shield, major medical, etc.
c. method of payment--fee for service, prepayment, etc.
B. Organizational Correlates
1. Alternative organizational forms
a. prepaid group practices
b. solo fee-for-service plans
c. comprehensive health care plans for low income enrollees
C. Availability of Services
1. Region
2. Residence (rural-urban)
3. Distance
4. Supply of medical personnel and facilities
a. physician-population ratio
b. hospital bed-population ratio
5. Regular source of care

III. NEED

A. Health and Mobility Status
B. Perceived Symptoms of Illness
C. Physician-Rated Urgency
D. Chronic Activity Limitation Status
E. Disability Days
F. Diagnosis
G. Surgery

Certain of these health-medical care correlates and variables for investigation were included in the scope of the survey (see interview guide in Appendix).

The concept of need is commonly referred to as any lack or deficit within an individual, either acquired or physiological. Thus needs might be physical, psychological, sociological, or a combination of these. Needs imply an impetus to behavior (drives and motives) in order to achieve a goal. This general context of need with health/medical care as the subject referent will serve as a general point of reference. It is advisable that a precise operational definition of need is not preconceived and superimposed as the conceptual framework of the study. In this way, flexibility is provided for the reported definition of need evolving from a direct response of the people at the local grassroots level.

II F

REVIEW OF THE LITERATURE CONCERNING FOUR VARIABLES

Of particular interest as variables and correlates of health medical care behavior in New Mexico are education of head of household, head of household's ethnic group, annual household income, and household rural, urban location.

In a 1971 New Mexico study, Potter factor analyzed 78 variables from 1960 U. S. Census data for 32 counties in New Mexico. Although the analysis did not enable establishment and differentiation of variable effects by county, the variables included were demonstrated by numerous other studies as related to variations in health and illness. The number of variables considered was reduced by the statistical analysis to a few variables used to explain approximately 43% of the variance among the 78 variables. Variable factors with high numerical scores included: proportion of males, twenty-five years of age and older, with sixteen and more years of school completed; proportion of families with a household income of $10,000-14,999 a year; and rural-urban household distinctions frequently considered to be important in health and illness differences. Moderate correlations were obtained for the aforementioned variables and certain measures of morbidity and mortality such as "selected causes of infant deaths". Selected causes of infant deaths included a high proportion of males with one-seven years of schooling; the absence of a middle class (twelve years of education for males and $6,000-9,999 per year family income); and a large proportion of the population living in places of less than 1,000. (New Mexico Community Profiles, No. 1, 1971)

EDUCATION

Most study results indicate that the variable of education is an important determinant in the health-medical care usage situation, particularly preventive health behavior. Consumption of medical-health care services increases as educational level increases. In a study of mothers attitudes in Baltimore, Maryland, Aday reported in 1971 a higher number of yearly physician visits and physical examinations for children under fifteen in relation to increases in mother's education. [3] Bice and White reported years of individual education as a significant factor in whether or not they had undergone a general examination within the preceding year.[14] Ross, in an analysis of National Health Center data, concluded that education is directly related to the use of physician services. Furthermore, the type of service sought is directly related to education with the higher levels making greater use of preventive services.[63] A U. S. sourcebook indicated

families with male heads of household, with five years of education, averaged four physician visits per year. Those heads of household who attended college averaged 5.4.[75]

Results reported in 1970 from a comparative health behavior study between the United States and Sweden, mentioned higher levels of education as a predictor for increased dental care utilization.[4] The publication, Volume of Physician Visits: United States, indicated a higher number of physician visits with increased levels of educational attainment. This relationship applied particularly to younger age groups whose knowledge of preventive-care benefits increased with age.[74]

In contrast, Richardson and Freeman's panel study of male old age pensioners in Michigan suggested limited use of the social variable of education as a predictor of differences in use for the older age group.[60] Salber found that mothers utilization of neighborhood health center services was affected by mother's education to a minor extent.[64]

Numerous studies and data sources indicate that individuals with a higher number of years of education have a greater tendency to undergo preventive examinations and utilize preventive health-care. Colver, in a Detroit study of mothers seeking maternity care, found that the higher a mother's education, the greater likelihood of her use of prenatal, postpartum, and family planning services.[21] Donabedian and Rosenfeld reported that women with better education receive better prenatal care. Similarly, females with a higher number of years of education are more likely to receive dental care during pregnancy.[23] A study of characteristics among participants and non-participants in polio vaccine trials in Erie County, New York, mentioned a direct relationship between parents education and individual participation in preventive immunization.[84] In addition, results of a study by Andersen and Anderson of health care utilization and patterns of expenditures, concluded that educated individuals were more likely to have had a physical examination as a preventive health measure than were individuals in uneducated groups.[10] Ellenbogen measured the diffusion of two preventive health practices among rural New York residents over an eight year time period. Differences in acceptance of preventive dental examinations among age groups decreased for those persons with a correspondingly high education.[25]

Fink described factors which contributed to reluctance to participate in a cancer screening program. Participants were found more likely to be younger and better educated than non-participants.[27] Clausen appraised characteristics and attitudes of mothers which influenced their children's participation in polio vaccine trials.

The findings of this study indicated that education was a major factor in the difference between mothers allowing their child's participation versus those who did not. Consenting mothers were more likely to be better educated.[4]

In contrast, an appraisal by Dodge of maternal desires for child health care in the southwestern county of Galveston, Texas, found no significant differences among mother's education levels in the assignment of relative importance to health measures.[22]

Results of health care services concerning hospitalization vary according to education. Feldstein's model of demand for health care includes family education as a variable directly affecting patients demands for services.[26] Fitzpatrick's study described the nature and effectiveness of hospital utilization in Michigan by certain measures such as length of stay. The authors include a persons's education as one of several important correlates interrelated with duration of use of hospital services.[28] In contrast, J. G. Anderson maintained that education has little effect on the use of services. Results pertain to his demographic model for predicting utilization of hospital services.[6]

INCOME

Income is an important variable in the health-medical care usage situation.[80] Rosenstock maintains that although it is difficult to separate the effects of education from those of income, there is a sound basis for believing that effects of education and income are at least partly independent, particularly with regard to preventive health behavior.[11]

Purola reported increased utilization of physician's services with increased levels of income in a study of 6387 families.[59] Also, Ross stated that income was directly related to the use of physician services. This relationship applied to every age-sex group in an analysis of National Health Center data.[63] Sparer and Okada discovered a direct relationship between preventive dental care and income in a study of eight national OEO Neighborhood Health Center service areas.[67] E. L. White's secondary data analysis showed that the proportion of each income group that had a physician visit within the past year increased as income rose.[83] An additional study by Klem concerned insurance coverage and other factors related to utilization of physician services. Family income was determined to be directly related to inclusion in insurance coverage. Within income categories, individuals with insurance coverage were more likely to receive services than persons without coverage.[42] Kovner found that for persons using uninsured outpatient services, use of such services was directly dependent on level of income.[44] Kegeles stated that income accounted for a larger proportion of variation in taking a Papanicolaou test than does education. Also, income appears to be more relevant for preventive health-medical care services entailing expense.[11]

In contrast, O. W. Anderson reported little difference by income group in the volume of surgical services sought.[8] Moreover, Bice and Eichhorn concluded that, from a review of literature and health survey data, the traditional relationship between income status and use of physician services diminished over the past four decades. This was partially attributed to a narrowing of the gap between high and low income groups and increased insurance coverage and availability.[15]

Income is an important determinant in use of preventive health-medical care services. Freeman and Lambert found a significant positive relationship between family income and participation of mothers in preventive dental behavior.[29] Similarly, findings of a nationwide survey positively related use of dental services to higher family income.[7] Moreover, Kriesberg and Treiman examined the impact of selected factors on teenagers' use of preventive dental services. Financial resources were specified as a major usage factor. The higher the income the higher was preventive dental utilization.[4]

There is a positive relationship between income and use of health-medical care specialist services. In a study of the relationship between poverty to health status and services utilization, there was a greater tendency among high income groups to utilize such specialist services as pediatricians and obstetrician-gynecologists.[61] Muller reported consistently higher use of specialists by high income families from National Health Survey data.[51]

Income is a determinant of the setting in health-medical care service usage. Various studies indicate that people of lower incomes are inclined to obtain physician services in hospital emergency rooms and clinics. Richardson's study concerning the relationship of poverty to health status and service utilization, showed that families with incomes less than $3,000 were more than twice as likely as those in higher income groups to seek physician services in hospital clinics and/or emergency rooms.[61] White also reported that low income families showed a greater tendency to seek physicians services in outpatient clinics.[83]

RACE AND ETHNICITY

Concerning race and ethnicity, literature suggests that a person's race influences the volume of services consumed and the site of the visit. Findings are ambivalent with regard to the direction of such relationships. The relationships are reported to be independent of differences in individual and household income.[3] Pomeroy's study among welfare families in New York City reported substantially higher total medical utilization among Negroes versus Puerto Ricans or Whites.[55] A U. S. Public Health Service survey of dental care utilization patterns in St. Louis reported that blacks received less care than whites. Also blacks received most of their care at a clinic, more frequently in an

emergency situation.[78] Furthermore, a study by Nolan assessed the differences in use of services among different ethnic groups and social classes. It was determined that whites, regardless of social class, divided their visits almost equally between appointment and drop-in clinics. Most Negroes visited the latter. Eighty-six percent of the whites had a regular pediatrician in comparison to 68% of the Negro children.(Am. J. of Pub. Health, 57, Jan., 1967, 34-47).

R. Andersen and O. Anderson studied health care utilization and patterns of expenditures. Race was related to both utilization and expenditures insofar as nonwhites comprised 15% of the total sample but only 9% of those with hospitalized illness and 12% of those with non-hospitalized illness.[10] Richardson considered certain factors associated with poverty, including race, in relation to health status and utilization. Average physician visits were found to be much lower for nonwhites than for whites. Racial differences with regard to dental care were more pronounced than for physician services.[61]

Race and ethnic background are important variables in utilization of preventive health-medical care services. Information from the U.S. Public Health Service, a national sample of 35,000 households, indicated that blacks were less likely than whites to have participated in polio vaccine trials.[79] In contrast, Winkelstein and Graham found that nonwhites participated more than whites in polio vaccine trials in Erie County, New York.[84] Podell, in a sample of 2179 female heads of household receiving public assistance in New York City, found that white mothers in the population made less use of preventive services than Negroes and Puerto Ricans. However, white mothers were more likely than the others to have received prenatal care in the first trimester of pregnancy.[54] Fink studied reluctance among various persons to participate in breast cancer screening programs. Results indicated that more Jews than other ethnic groups were more likely to have seen a physician for screening within the past year.[27] In addition, Morris examined mother's social isolation and perceived sense of powerlessness in relation to seeking preventive services for their children. Whites in the lowest occupational stratum were likely to seek care regardless of social isolation. Less educated whites sought care regardless of their sense of powerlessness. More educated whites sought care irrespective of social isolation. Negroes did not seek services whether or not they indicated alienation.[50]

Ethnic group and race were considered in certain medical-health care studies among Mexicans and Spanish-speaking peoples. Loomis examined the failure of a cooperative health association in Taos County, New Mexico. He concluded that physicians and staff failed to win the confidence of common people because they failed to attempt to understand ethnic and cultural aspects of folk medicine, beliefs,

and practitioners (curandero, yerbero). These results imply central concern for and direct attention to the hypothesized importance of folk medical practices and beliefs.[45] Adams and Rubel considered features of illness, diagnosis, and curing among the Spanish-speaking villagers of Middle America. They concluded that ethnic related factors of belief in anthropomorphic and other volitional factors can be, but are not necessarily, an accurate index to their role in health treatment. Causes of illness, and cures assigned, were determined to be completely dependent on the conceptual categories of illness causation current in the community. Treatment by limited practitioners or socio-ritual curers depended on access and familiarity established through social relations and diagnosis.[2] In addition, Schulman discussed the role of ethnic group in determining rural healthways in New Mexico. The elements of folk medicine and a distinguishable ethnic folk culture were isolated as two variables in a multicausal system of illness and alternatives for treatments and therapy.[57, 66]

In contrast, Octavio Romano maintains that Mexican-Americans are locked into a traditional culture that labels and characterizes them primarily through the use of stereotypic terms.[17] Such models are inappropriate for describing Chicanos who are a pluralistic people. A primary weakness of classificatory models is that they assume each minority is itself monolithic. Also, they consider all minorities as being alike. This criticism applies to explanations of ethnic factors in explanations of Mexican health care.[20] Nall and Speilberg studied responses of Mexican-Americans to modern medical treatment regimes for tuberculosis in the Rio Grande Valley of Texas. Findings indicated no inhibitory effect of ethnic folk medical beliefs and practices on either the acceptance or rejection of modern treatment regimes. Results did suggest the importance of a "milieu effect" of integration into the Mexican-American sub-community, especially the importance of the family unit as inhibiting acceptance of a modern treatment regime among subjects in the study.[52] Moreover, Suchman compared ethnic groups in New York City relative to variations in disease knowledge, attitudes toward medical care, and behavior during illness. In general, it was determined that the form of social organization was more important than ethnic or social class factors in relation to sociomedical responses.[76]

RURAL-URBAN HOUSEHOLD LOCATION

The variables of household rural or urban location and distance are related to the health-medical care usage situation. O. Anderson and R. Andersen reported results from a 1963 national survey. Findings indicated that people in cities had the lowest hospital admission rates and people in rural-non farm areas the highest rates.[9] Another study conducted by O. Anderson and R. Andersen discovered that hospital admissions for surgery were lower for rural farm people than for others. Urban residents in the largest standard metropolitan areas and also rural

farm residents had lower hospital admission rates than other residents.[10] Wirick reported that rural-urban location did not influence the percentage of population using hospitals.[85] The national pattern of physician visits was shown as highest among residents of standard metropolitan areas and lowest among persons living on farms outside of standard metropolitan areas.[74] The source, Health Characteristics, 1967, reported rate of physician visits as greater in metropolitan areas and lowest for farm residents outside standard metropolitan statistical areas. A study by Avnet reported service utilization rates similarly affected by geographic location of residence.[12] Metropolitan area patients reportedly had the longest stays in hospitals with an average of 8.7 days as compared to 7.4 days for non-farm and 6.0 days for farm residents.[8]

Results concerning distance indicate its importance in considering the site for a physician visit. However, findings of distance as it affects the volume of services consumed are not clear. Abernathy and Schrems determined that close proximity to a primary care facility positively influenced family's use of that facility. Mexican-Americans were found to be least affected by location convenience in choice of facilities. However, distance from facilities was not an influential factor in families overall utilization of services.[1] In contrast, Jehlik and McNamara studied the relation of distance to differential use of health personnel and facilities. Findings indicated that persons who drove a greater distance from the facilities had a tendency for lower physician visit rates.[36] Purola discovered that distance to and availability of medical resources were major needs in the gap between medical need and use of facilities.[59] In addition, Weiss analyzed the effect of distance between patient and utilization of physician service in the metropolitan area. It was determined that in use of a common source of medical care by a diverse metropolitan population, distance traveled is an important factor. Sixty-four percent of all visits to the physician were made to the nearest facility. The type of specialty available at the nearest clinic significantly influenced travel to the clinic. More people traveled farther to a central clinic where specialist resources were located than for the services of pediatricians and internists available at neighborhood clinics.[82]

II G

THE CONCEPTUAL RELATIONSHIP BETWEEN EXPERIENCE AND EVALUATION

The link between experience, for example health-medical care services/facilities utilization, and such subsequent evaluations as reported satisfaction or dissatisfaction of use, is drawn from the field of social psychology. Human action is for the most part motivated or goal-directed. Furthermore, human action is integrated insofar as each person's wants, emotions, and cognitions operate in concert to influence his actions and evaluations as they relate to and proceed in the direction of goal achievement.

The psychological history of an individual, and his predisposition for future action, is a record of past experiences unique to him. The content and organization of a particular cognitive image, such as a previous usage experience with a health service or facility, are molded by past experience. Each cognitive organization has two main kinds of determinants: stimulus factors (factors derived from the nature of the external stimulus object) and personal factors (factors which result from the characteristics of the perceiving individual). Individual differences in experiences occur as a result of perceptual and cognitive selectivity. Each individual's differences in experience may arouse momentary mental sets which influence or govern future action by differentially sensitizing the individual to certain objects in his world or particular elements of the same object. Nevertheless, to understand what a person sees when he looks at an object, his cognitive image of a health care usage experience, it is necessary to know the perceptual properties of the system of which this object is a single member. A primary function of past experience, in relation to future action, is the establishment of a frame of reference which denotes the larger contextual system with respect to which an object is viewed or judged.13

Thus, past experience as a frame of reference is functionally interrelated to the evaluative process of an object. Implications for future action, such as use of health care services/facilities, depends upon the interrelationship of past usage experience and attitudes as primary components of the evaluative process. Past experience as a frame of reference serves as an information base in a causal sequence of events and attitudinal evaluation. Attitudes contain four components: cognitive, affective, action, and evaluative. The evaluative attitude component is a value judgment expressing satisfaction or dissatisfaction with an object or cognitive image such as previous health care utilization experience.

Thus the health-medical care services/facilities usage experience is common to many persons. However, this experience is differentially perceived and evaluated. This is due to individual background and situation variables which are often primary determinants accounting for differences in experience evaluations and reported levels of satisfaction or dissatisfaction.

II H

SURVEY ANALYSIS

Analysis determination and presentation of results requires consideration of the survey nature, purpose, and objectives. Conduct of the survey is not in the form of a classical experimental study with manipulation of independent variables or treatments. The survey, similar to much of social science research, is an ex post facto determination of information.

The gathering of consumer health-medical care information in the Southwestern consortium is in the initial stage of an analytical process. It is first necessary to ennumerate and describe relevant situation factors as prerequisites to more sophisticated analyses and explanations. To this end, a descriptive (frequency and percentage) treatment of the data and analysis was used. Moreover, limiting factors of time, the State CHESS Coordinators request, and consideration of the report audience group, determined the need for a descriptive analysis.

In the long run, additional health-medical care investigation and empirical studies in the consortium should be concerned with presentations and analyses which illuminate the precise factors that account for differences in health-medical care behavior. Progress in understanding the illness process, and the interrelationships of consumers and providers, requires development of a predictive social-psychological model, specification, measurement, and analysis of integrated variables. Such a model would provide an understanding of how people realize that they are ill, how they decide that some form of assistance is necessary, and causally relate these phases to what they do about it.*

A second analysis involved use of the chi square correlational statistic. It was used to test the following four null hypotheses:

> There will be no significant difference among survey respondents in responses to reported household satisfaction with health/services care received according to differences in annual household income.
>
> There will be no significant difference among survey respondents in responses to reported household satisfaction with health/services care received according to differences in head of household's education.
>
> There will be no significant difference among survey respondents in responses to reported household satisfaction with health/services care received according to differences in heads of household's ethnic group.

*The conceptual/action orientation of elements in the health-medical care process, included in this report, is a step in this direction.

There will be no significant difference among survey respondents in responses to reported household satisfaction with health/services care received according to residence location (rural or urban).

III

OVERALL RESULTS

For the most part descriptive findings and analyses are presented emphasizing results as they pertain to the Southwestern CHESS consortium as a composite unit of four hundred personal interviews completed in eight New Mexico counties. Because of the sampling design, proportional by county according to population, the number of interviews completed in each county are not equal. Percentages take into account numerical differences in base totals. Nevertheless, it should be recognized that in some instances comparison of certain variables, such as county location, is limited or impractical as a result of numerical differences. Moreover, the New Mexico State CHESS Coordinator requested that data interpretation emphasize the Southwestern consortium as a unit. Selected individual analyses by county and other variables are included where practical.

1. County Residence Location (Exhibit 1)

Among total completed personal interviews in the Southwestern consortium, approximately 64% were obtained in the adjacent counties of Dona Ana and Otero. Greater than 60% of the eight county population is located in this southern middle and southeastern area of the consortium.

2. Nearest Population Health Center Location (Exhibit 2)

As might be expected, nearest population health center locations parallel county population trends. More than 60% of household members in the survey would logically be expected to receive health care services, use medical facilities, and receive health related education/training in Las Cruces (Dona Ana County) or Alamogordo (Otero County). A determination of logical expectation for use of health related services/facilities was an interviewer responsibility. Up to date rural and urban maps were marked, according to the sampling frame, for selected respondent households. Interviewers examined the household residence location in relation to a list of health center locations, accessible roads, and shortest distance. Through use of these criteria, it was possible to logically determine household residents' most frequent usage targets for health services/facilities, excluding motivational factors. It is recognized that personal or motivational considerations may be significant determinants for a particular household's determination of where they go for services/facilities/education. However, the primary purpose of this project was not an in-depth motivational survey. Aside from certain information concerning motivational factors, obtained in this survey as a by-product, an additional in-depth study would be needed to more fully explore the interrelationships and effects among matrices of socioeconomic and individual background variables, motivational factors, and individual situation variables, relating to a selected dimension of health-medical care.

3. Approximate Distance To Nearest Accessible Population Health Center/ Services (Exhibit 3)

This approximation was calculated by interviewers using their maps before the start of the personal interview. Approximately 40% of survey household residences were located within 10 miles of nearby population health center/services. This percent combined with a number of likely suburban residents at the low end of the 11-20 mile category corresponds to the 45% total of urban respondents in the sample of 400. Twenty one percent of the respondents were located over 50 miles. This percentage most likely includes rural residents and residents of small towns.

Distance by mileage category	% of Total responses
Total no. respondents 400	100%
Resident	28
Within 5 miles	5
6-10	6
11-20	14
21-30	10
31-40	9
41-50	8
over 50	21

4. Urban or Rural Residence Location (Exhibit 4)

As discussed in the sampling section of this report, 55% (220) of the survey households were located in rural areas of open rural, farms, ranches, or less than 75 people in a small village or cluster of residences separated by an equivalent distance of not more than six average city blocks. Forty-five percent (180) of respondent households were located in urban areas and small towns.

5. Health Care Location Most Frequently Used By Households (Exhibit 5)

For the consortium, approximately two thirds of the respondents reported household members most frequently use a nearby population health center. Cross tabular analysis reveals that the nearby health center most frequently used is not always the logical choice in terms of closest distance.

Approximately one-third of the total respondents (129) reported use of "other health centers." These "other health centers" were all located outside of New Mexico with the exception of Albuquerque reportedly used most frequently by 14 households. Examination of interview guides and respondent comments revealed a variety of possible reasons for use of "other health centers." These included motivational factors (preference for a particular physician or avoidance of a certain facility or personnel), need for a specialist, economic factors (some well-to-do cosmopolites), perceived quality differentials, and nearby geographical location.

6. Current Financial Protection For Head of Household (Exhibit 6)

Eight percent of heads of household among respondents in the Southwestern consortium are reportedly not covered by financial protection or don't know if they are covered (1%). The highest percentage for category of coverage was 30% for group insurance at work.

Twenty-nine percent (112 persons) of the total of 389 persons who responded to the question, reported the head of household was currently covered by more than one source of financial protection.

7. General Household Health Level (Exhibit 7)

Over 80% of the 399 responses to this question categorized overall health levels of household members as excellent (rare sickness) or good (some sickness but infrequent). Less than 20% of those interviewed classified their household health level as fair (some sickness alternating with good health) or poor (continuous or frequent sickness of some type).

8. Members of Household with Special/Recurrent Health Problems (Exhibit 8)

A large proportion, 70%, of individuals replied that no household members had special/recurrent health problems. Thirty percent of households reported such afflictions for one or more individuals.

9. Special/Recurrent Health Problems (Exhibit 9)

One hundred and twenty households reported special or chronic health problems for members. Arthritis was specified as the most frequent problem by 17% of the respondents (20 households). Second was diabetes mellitus, 12%, followed by heart trouble, 10%, and sinus, hay fever, allergies, 10%.

10. Existing Household Needs To Facilitate Care of Special/Recurrent Health Problems (Exhibit 10)

Twenty-seven percent of households whose members reportedly had special/recurrent health problems reported a need for health care personnel closer to the household residence location. In addition, 20% specified the need for a specialist. Another group of respondents, 20%, mentioned the need for physical and mechanical equipment (air conditioner, respirator, etc.).

11. Existing Needs For Rehabilitation Of Household Members With Special/ Recurrent Health Problems (Exhibit 11)

Among survey respondents 25% specified a need for improved professional care in the form of a specialist for household members with special recurrent health problems. A need for physical therapy and stronger glasses for the individual each received 20% of responses.

12. Three Most Important Symptoms Used In Determining Illness (Exhibit 12)

Change in body temperature (fever and chills) received the highest percentage of response (26%) among all symptom category mentions. Bodily aches and pains ranked second with 17%, followed by change in behavioral habits (sleep, sex, appetites), 16%. According to ranking of importance among symptoms, body temperature received the highest percentage (42%) among first choice symptoms and was also first (21%) among symptoms mentioned as second choice.

13. Sources of Influence In The Illness Process (Exhibit 13)

The physician (general practitioner or specialist) was reported as the single most important source of influence in every stage of the illness process except deciding recovery. In the latter stage "myself" was recorded as the most important source of influence by 51% of the respondents, followed by the physician, 42%. Relatives were a more important source of influence in each stage of the illness process than friends.

14. Household Members Who Used Health Manpower Services In The Last Five Years (Exhibit 14)

The physician specialty of General Practitioner was used more than any other manpower service category by 347 households. Sixty-nine percent of these respondents evaluated their usage experience as excellent, 16% good, 9% fair, and only 3% as poor. Similarly other services used frequently, and highly evaluated include M.D. specialist, Dentist, Optometrist, and Pharmacist. Midwives, Naturopaths, Astrologers, Faith healers, Yerberos, Curanderos, and Brujo(a)s were infrequently used.

15. Household Members Who Did Not Use Health Manpower Services In The Last Five Years (Exhibit 14a)

For all categories of manpower service, more than 85% (depending on the specific category) of respondents not using such services reported no need for such usage. In general, varying according to each category, respondents reportedly knew about such services. For example, among 53 respondents who did not use a General Practitioner/Family Doctor, 87% did not need to use one and 13% said they needed to use one but did not. Among these 53 persons 87% knew about General Practitioner/Family Doctors and 13% reportedly did not (they might not have known one or one nearby).

16. Households Whose Members Used Health Related Facilities In The Last Five Years (Exhibit 15)

The drugstore, home treatment facilities, physician and dentist offices, and community hospitals were reportedly used most frequently. Community hospitals were evaluated as excellent by 68% of respondents, good by 15%, fair by 8%, and poor by 8%. Physician and dentist offices were rated as excellent by 77%, good by 12%, fair by 8%, and poor by 2%. Hospital emergency rooms were rated excellent by 67% of interviewees, good by 6%, fair by 10%, and poor by 15%.

17. Households Whose Members Did Not Use Health Service Facilities In The Last Five Years (Exhibit 15a)

Ninety-seven to 100%, depending on the facility, of respondents who said they did not use a health related facility reported no need for use.

A high percentage of respondents reportedly did not know about special migrant worker facilities, mobile diagnostic and treatment units, sanatorium, nursing homes for the aged, neighborhood health clinics, and U.S. Public Health Service Facilities on Indian Reservations. This is probably due to the limited and differential availability and access to such facilities as a result of household situation variables such as location.

18. Household Members And Conditions For Use Of Health Related Services/Facilities In The Last Five Years (Exhibit 16)

Conditions related to out-patient diagnostic laboratory work, toothache and tooth repair, viruses, broken bones, major surgery, and minor surgery were reported as conditions most frequently associated with use of health related facilities. Use of facilities for these related conditions received high evaluation.

It is interesting to note that only 25 households reported visits to family planning connected services/facilities. Among those who utilized services/facilities for this subject, 96% reported an evaluation of excellent. Only eight households reported use of facilities for mental/emotional/alcohol/and non-alcohol drug abuse.

19. Household Members Who Did Not Use Health Services/Facilities In The Last Five Years Regardless Of Condition (Exhibit 16a)

In general respondents who did not use services/facilities, regardless of related conditions for use, reported no need for use. For the most part, with the exception of "susto," mental/emotional/alcohol/non-alcohol drug abuse, chiropractic adjustments, and family planning services, most households said they knew about such services/facilities with regard to conditions for use.

20. Household Members Who Used Diagnostic/Preventative Services In The Last Five Years (Exhibit 17)

Two hundred and thirty-eight households reportedly used services for diagnosis and prevention (such as T.B. X-ray, T.B. patch test, cancer pap smear, diabetic urinalysis detection). One hundred and ninety-nine households had taken advantage of regular physical examinations. Also 153 respondents reported use of vaccination and innoculation. Such services, when used, were highly valued.

21. Household Members Who Did Not Use Diagnostic/Preventative Services In The Last Five Years (Exhibit 17a)

With the exception of a regular physical examination, most respondents who said they did not use diagnostic/preventative services reported no need for use. Forty-six per cent of respondents said they did not know about sex education and venereal disease prevention. Similarly, forty-eight percent reportedly did not know about nutrition.

22. Household Members Who Used Pregnancy, Prenatal, And/Or Postnatal Services In The Last Five Years (Exhibit 18)

Among the survey respondents, 74 households reported use of prenatal services, 69 used delivery services, and 52 used postnatal, pediatric, and child health care.

23. Household Members Who Did Not Use Pregnancy, Prenatal, And/Or Postnatal Services In The Last Five Years (Exhibit 18a)

Ninety-nine percent of respondents not using prenatal services said they did not need to use these services, 99% for delivery, and 97% for postnatal/pediatric health care. These figures represent a combination of factors relating to a need for education among certain households and other living situations which require no prenatal or child health care. It is probable that a significant proportion of the percentages reporting no need for use should be interpreted as, and translated into, an educational opportunity. This is illustrated by the NMRMP's determination (see Potter) of high infant death rate and poor maternal and child health care in certain underdeveloped areas of New Mexico. Also, approximately 45% of households reported they did not know about prenatal, delivery, and postnatal/pediatric health care.

24. Household Satisfaction With Health Services/Care Received (Exhibit 19)

More than two-thirds of the persons interviewed replied that their household was very satisfied with health services/care received. Twenty-three percent said they were partially satisfied. In contrast, 2% reported they were partially dissatisfied and 4% very dissatisfied.

25. Preferred Means Of Learning More About Health/Medical Care Education (Exhibit 20)

Individuals interviewed in the Southwestern consortium selected television and radio as their most frequently mentioned preferred means of health care education (20% of responses). It is interesting to note that adult education courses received the second highest percentage of responses, 18%. The written medium of newspapers and magazines was selected by 13%. A like percentage chose special literature and pamphlets.

26. Preferred Topics For Health/Medical Care Learning/Training (Exhibit 21)

General household health care was chosen most frequently by 16% of those responding to the question. Emergency first aid was second as selected most often by 15% of the respondents. Preventative health care topics, such as dental hygiene and nutrition were less popular, 7% and 6% respectively.

27. Household Need For More Health Education/Training (Exhibit 22)

Fifty-nine percent reported yes and 41% said no.

28. Was Respondent Head Of Household (Exhibit 23)

There was an approximately equal split among individuals interviewed relative to head of household status. Forty-eight percent reported they were the head of the household and 52% said they were not.

29. Age Of Head Of Household (Exhibit 24)

The range of ages for heads of household was from age 20 to 89. The mean age of heads of household was 48 years.

30. Age Of Respondents Not The Head Of Household (Exhibit 25)

The ages of respondents varied from 25 years to 83 years. Mean age of respondents was 41 years of age.

31. Respondents Relation To Head Of Household (Exhibit 26)

For those respondents interviewed who were not the head of household, 45% reportedly were the spouse.

32. Respondents Sex (Exhibit 27)

Sixty-one percent of the respondents were female and 39% male.

33. Duration Of Residence (Exhibit 28)

Approximately one-fourth, 24%, of the interviewees had lived in the state of New Mexico for a period of 1-10 years. The majority of respondents, 76%, had lived in the state for longer periods of time, varying between 11-70 years.

One-third of the persons interviewed, 33%, reported their household members had resided in their current county of residence for a time period of between 1-10 years. The remainder of individuals had lived in their present county for a longer period of time.

More than half of those queried, 57%, mentioned they had lived at the same address for a time period of 1-10 years.

34. Number Of People Living In Household (Exhibit 29)

The greatest frequencies were recorded for households with two-five residents. The highest percentage, 29%, reported two persons living in the household. Seventeen percent reported three residents and a like percentage claimed four residents. Five occupants were reported by 12%.

35. Household Income Before Taxes (Exhibit 30)

More than two-thirds, 19%, of households reported annual incomes between $6,000-8,999. Three percent of respondents reported annual income of less than $1,000 and 18% were between $3,001-5,999.

36. Head Of The Households Religion (Exhibit 31)

Close to half of the heads of household were Protestant, 47%. Thirty-nine percent were Catholic and 10% reported no religion.

37. Ethnic Group Of Household Head (Exhibit 32)

The two predominant ethnic groups in the survey, and also in the Southwestern consortium, were Anglos (60%) and Mexican-Americans, Spanish-Americans, Mexicans (35%). Indians accounted for 3% of the survey respondents and blacks 1%.

38. Highest Grade In Schcol Completed By Head Of Household (Exhibit 33)

The highest percentage recorded for heads of household, 25%, was for high school graduates. Eight percent were four year college graduates and 5% had finished graduate school. Twenty-one percent had completed less than seven years of school.

39. Occupation Of Head Of Household (Exhibit 34)

Heads of household were most frequently reported as unskilled employees (23%). Twenty percent of respondents were specified as skilled manual employees. In contrast, 8% were classified as higher executives of large concerns or major professionals.

40. Employer Of Head Of Household (Exhibit 35)

An equal percentage of heads of household, 29%, were self-employed or worked for a private company. Eighteen percent were reported as retired.

41. Does Head Of Household Currently Have A Drivers License (Exhibit 36)

Ninety-one percent reported the head of household currently had a drivers license.

42. Does Head Of Household Currently Have An Automobile (Exhibit 37)

Ninety-two percent of household heads currently owned an automobile.

43. Classification Of Roads Near Household (Exhibit 38)

Most roads near the household were reported as always accessible or passable most of the time (62% and 34% respectively). Four percent reported seasonal non-passable roads.

CROSS TABULAR ANALYSIS AMONG SELECTED VARIABLES

44. Residence County Location By Most Frequently Go For Health/Medical Care (Exhibit A)

As previously discussed, the number of completed interviews in each county varied considerably according to proportional population sampling. Thus any county to county comparison must take these numerical base differences into account as a restriction limiting or preventing comparative interpretation. Within each county, except for Catron and Hidalgo county, approximately 50% or more of the households said their members frequently go to a nearby population health center, for medical care, located within the same county as residence location. For example, within Dona Ana County (representing 40% of the sample of 400 interviews), 60% of those interviewed most frequently used Las Cruces for health/medical services. One might logically expect a large proportion of Dona Ana County residents to use Las Cruces, a large population health center within the county for medical care. In contrast, other residents used resources located outside of the county. One percent of households used

Deming most frequently, 2% used Silver City, and 2% used White Sands. Furthermore, 44% of the respondents used a major health center such as El Paso (22%) or others (12%).

Catron County is demographically classified as 100% rural by various statistical sources. Accordingly, there is a critical lack of health-medical care services and facilities within the county. As a result of this situation, all residents interviewed reported they obtained medical care in other locations outside Catron County (25% Silver City, 25% Socorro, 33% Albuquerque, 8% Belen, 8% Tucson).

45. Residence Location By Most Frequently Go For Health/Medical Care (Exhibit B)

Among households in the survey according to their rural or urban location, nearest large population health centers across the board were visited by a slightly larger percentage of urban residents. However, major health centers were visited by a slightly higher percentage of rural residents.

46. Nearest Population Health Center/Services By Most Frequently Go For Health Medical Care (Exhibit C)

Except for Socorro, greater than 50% of households reported they most frequently obtained health-medical care services from the nearest large population health center, with regard to residence location. For persons interviewed, 50 households were geographically nearest to Silver City as a population center for health services. Among these residents, 80% used Silver City most frequently for health medical care. Forty-eight percent of those who would logically be expected to use Socorro for health services, in terms of shortest distance, did so.

47. Financial Health Protection By Household Income (Exhibit D)

Results indicate percentage of households reporting no financial protection for the head of household was greatest for the lower income categories (under $1,000 year, 11%; $1,001-3,000, 30%; $3,001-5,999, 35%; $6,000-8999, 16%). Similarly, although few in number, the highest percentages among those stating they did not know whether or not the head of the household was covered by financial protection, was for the lower income groups ($1,001-3,000, 29%; $3,001-5,999,29%; $6,000-8,999, 14%). Private insurance and work connected insurance were the most frequent categories of coverage for all income groups.

48. Sources Consulted First For Establishing Illness Diagnosis By Respondent Ethnic Background (Exhibit E)

For all the ethnic categories except Indians, those interviewed stated that the physician was the single most important source consulted for illness diagnosis. Among all respondents the physician source was selected

by 79%. Folk medicine sources and black magic were not reported as a source of influence in this stage of the illness process. Indians reported relatives as the most frequent source consulted in establishing diagnosis.

49. Important Symptoms Used In Determining Illness By Ethnic Background Of Respondent (Exhibit F)

Among the total respondents for all ethnic groups, fever was most frequently mentioned as an important symptom used in determining illness. Between the two numerically dominant ethnic groups in the survey (Anglos and Spanish,Mexican-American, Mexican), and in the consortium, there was a correspondingly similar hierarchy of symptom use for determination of illness.

50. Household Health Assessment By Reported Need For More Health Education/ Training (Exhibit G)

Among all respondents, 43% reported their household health assessment as good, 38% excellent, 13% fair, and 6% poor. A higher percentage of households in each assessment category, except poor, reported a need for more health education/training. Forty-six percent of respondents who reported their household health level as poor said yes to more education/training and 54% said no.

51. Households Reporting Need For More Health Education/Training By Preferred Means Of Education (Exhibit L)

Among individuals reporting a need for more health education/training, 20% mentioned television and radio and 18% adult education as the two highest percentages among preferred means of education.

52. Households With Special/Recurrent Health Problems By Reported Preference For Educational Means (Exhibit M)

Those households with special/recurrent health problems selected adult education courses, 20%, as the preferred means of education. It is possible that this reported desire for education would involve other household members aside from the person(s) with the problem(s). Households with no special/recurrent problems selected the same two most preferred means only in reverse order. Newspapers and magazines received noticeable interest among both groups.

53. Households Reporting Need For More Health Education/Training By Reported Topics To Be Included (Exhibit N)

Those respondents desiring more health education/training most frequently selected general household health care, 16%, as a preferred

topic. Emergency first aid was selected by 15% followed by homemaker, home nursing skills, 9%.

54. Reported Need For More Health Education/Training By Education Of Household Head (Exhibit O)

Respondents who said there was no need for more education were among the less well educated groups. The highest percent, 25%, who said no, was for those heads of household with under seven years of school, followed by 22% for high school graduates. It is interesting to note that among households reporting a need for more education, the highest percentage was recorded for high school graduates, 29%, and those with under seven years of school, 20%.

55. Reported Need For More Health Education/Training By Household Income (Exhibit P)

The highest percentages of interviewees who reported a need for more education were in the $6,000-8,999 group, 20%, and $3,001-5,999 group, 17%. Those who said there was no need for more education were concentrated in the $3,001-5,999 group, 20%, followed by the $1,001-3,000 category, 18%.

56. Reported Need For More Health Education/Training By Ethnic Background Of Respondent (Exhibit Q)

A higher percentage of Anglos than Spanish, Mexican-American, Mexican, reported yes to a need for more education. Similarly, a higher percentage of Anglos reported no need for more education than did other ethnic groups. It is noted that the number of members interviewed in each ethnic group varied.

57. Reported Need For More Health Education/Training By Residence Location (Exhibit R)

A higher percentage of rural respondents, 60%, versus urban, 40%, reported a need for more education/training. Conversely, a higher percentage of urban 52% stated there was no need for more education/training versus rural, 48%. It is noted that a greater number of rural interviews were completed as previously mentioned.

58. Household Satisfaction With Health Services/Care Received By Education Of Household Head (Exhibit H)

For all respondents, by education, 70% reported they were very satisfied with health services/care received. Within the group who were very satisfied, considering education of head of household, the highest percentage, 29%, was for high school graduates and those with under seven years of school, 24%. Eight percent of college graduates and 4% of professionals reported they were very satisfied.

Four percent of all respondents reported they were very dissatisfied and 2% partially dissatisfied. Among households who were very dissatisfied, the highest percentage, 25%, was for those with one-three years of college followed by 19% for seven-nine years of school.

59. Household Satisfaction With Health/Services Care Received By Household Income (Exhibit I)

For all households, by income, 70% were very satisfied and 4% very dissatisfied. Within the very satisfied group, the highest percentages were for the low income groups with 20% as the highest response in the $3,001-5,999 group. Nevertheless, the highest response among those who were very dissatisfied was 25%, also for the $3,001-5,999 group. Those households in the $15,000 and over groups reported the second highest percentage of very dissatisfied.

60. Household Satisfaction With Health Services/Care Received By Ethnic Background Of Respondent (Exhibit J)

With regard to all respondents from various ethnic groups, 71% were very satisfied and 23% partially satisfied, 4% very dissatisfied, and 2% partially dissatisfied. Although the number of Anglos and Spanish, Mexican-American, Mexicans in the survey differed, a higher percentage of Anglos than the latter group were very satisfied, partially satisfied, very dissatisfied, and partially dissatisfied.

61. Household Satisfaction With Health Services/Care Received By Residence Location (Exhibit K)

For both rural and urban respondents combined, 71% were very satisfied and 4% very dissatisfied. A higher percentage of rural households than

urban was recorded for each of the categories of satisfaction or dissatisfaction. This partially reflects the greater number of rural households in the sample (55% rural, 45% urban).

III A

OVERALL RESULTS SUMMARY

Analysis of the survey data indicates certain characteristics among consumers of health-medical care services in the Southwestern consortium of New Mexico. The total number of 400 survey respondents and the number of responses to each question, as well as items within a question, must be taken into account for purposes of interpretation and generalization of results.

Among respondents in the sample, for the consortium as a unit, slightly less than 50% to more than 75% of respondents use a nearby health center within the consortium. However, approximately 30% or more of respondents in each of the eight counties, except Grant and Luna, use a major health center located outside of the consortium. Reasons for the latter could include such factors as perceived higher quality, distance, and numerous motivational reasons. For purposes of planning additional services, facilities, health education programs, and personnel training, it is necessary to anticipate consumer use and audience participation in terms of this mobile "crossover effect" versus the mainstream of users. Rural residents were inclined to make slightly greater use of major health center facilities outside the consortium. It is noted that the location of some rural residents in the sample indicated practical considerations of distance and access to Albuquerque, El Paso, and Arizona health centers, as determinants of location choice.

The majority of respondents reported the head of household was currently covered by some form of financial health protection. Over one quarter were covered by more than one source. A small segment of low income households were reportedly not covered. Economic resources available for health care has been demonstrated to be an important enabling variable in use of health services/care.

Respondents in the sample reportedly perceive health care, as reflected in use of symptoms for illness determination and sources of influence in various stages of the illness process, more in terms of modern medicine and conventional American middle class diagnosis and treatment.

Approximately three-fourths of households in the sample were reported as having an excellent or good overall household health level. Less than one-third of households reported special/recurrent problems. The reported levels of good health was a determining factor in obtaining information to the extent that services/facilities/manpower were not used, needed, or desired.

Perceptions of health care were not greatly influenced by folk medicine, beliefs , practices, or other illness conceptions unconventional to many middle class Americans. The physician is reported to be in the central and most important provider role among health service manpower categories. Evaluation of physician services was rated as excellent among 69% using such services.

Health related facilities of drugstore pharmacy, physician and dentist offices, and community hospitals were most frequently used. Evaluation of such facilities varied from excellent ratings of 60% and above, to 2-15% for poor. Hospital emergency rooms received a poor rating for reportedly being understaffed, unclean, and requiring too long a wait for service attention.

Diagnostic services were used by 238 of the household respondents, mostly for annual checkups. Preventative services of vaccination and innoculation were used by 153 of the respondent households. This usage number is low, particularly considering the time frame of the previous five years. Those individuals who did not use such services reported they had no need for use. These results reflect a serious knowledge gap among consumers in the Southwest consortium. Accordingly there is a marked need for education concerning the role, and value for use, of diagnostic and preventative services.

Similarly, considering the previous five year time frame and mean age of respondents, a limited number of households reported use of health services for prenatal use (74 households), delivery (69 households), and child care (52 households). Among households not using such services, 45% reportedly did not know about the availability of such care. The latter point is partially understandable in view of other results from the survey indicating a shortage of pediatricians, midwives, and other categories of personnel germane to prenatal and child health care. Nevertheless, there is a need for more and improved health services education and/or better methods of delivery to the parental and child bearing segments of the population. The importance of past and current rates of infant mortality in New Mexico reported by Potter and others, indicates a long standing problem that needs to be met by additional focused effort and/or redirection of existing efforts.[56,57]

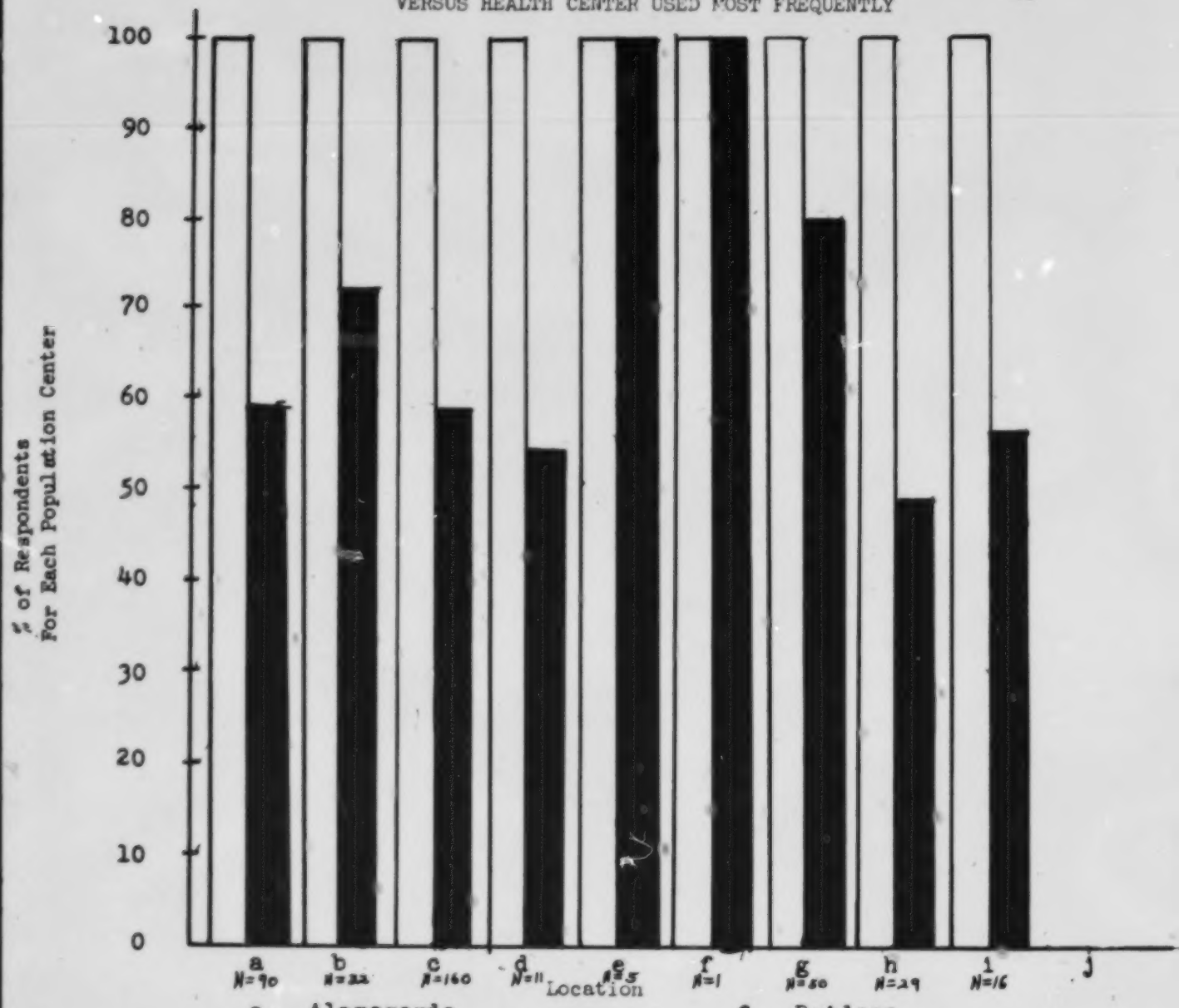
Two-thirds of all respondents indicated their household satisfaction with health services/care received. Only 4% were very dissatisfied. Reasons given for satisfaction or dissatisfaction illustrate and reinforce the primacy of the physician in the health care process. Numerous respondents structured their response with reference to physician services as opposed to mention of other health care personnel, facilities, or topics.

Need for more health education/training was reported by 59% of the respondents versus 41% who said no. Preferred topics most frequently specified were general household health care and emergency first aid. The most popular selected methods of learning were T.V. and radio, followed by adult education. The latter result is a mandate for development through joint and cooperative efforts utilizing resources within the quadrant.

According to the highest reported survey percentages, it was more likely that: respondents interviewed in the consortium were the head of household or spouse; female; reported to have lived in the state, county, and at the same address from one-ten years; have two or three household members; Protestant religion for head of household; Anglo ethnic group; either a high school graduate or less than seven years of schooling for the head of household; head of household was reported to be either an unskilled or skilled manual worker self employed or employed by a private company; head of the household possessed a driver's license and owned a car; nearby household roads were classified as passable most of the time.

III B Figure 1

HOUSEHOLD NEAREST POPULATION HEALTH CENTER VERSUS HEALTH CENTER USED MOST FREQUENTLY



a. Alamogordo
b. Deming
c. Las Cruces
d. Lordsburg
e. Mescalero
f. Ruidoso
g. Silver City
h. Socorro
i. Truth or Consequences
j. White Sands

NEAREST POPULATION HEALTH CENTER LOCATION

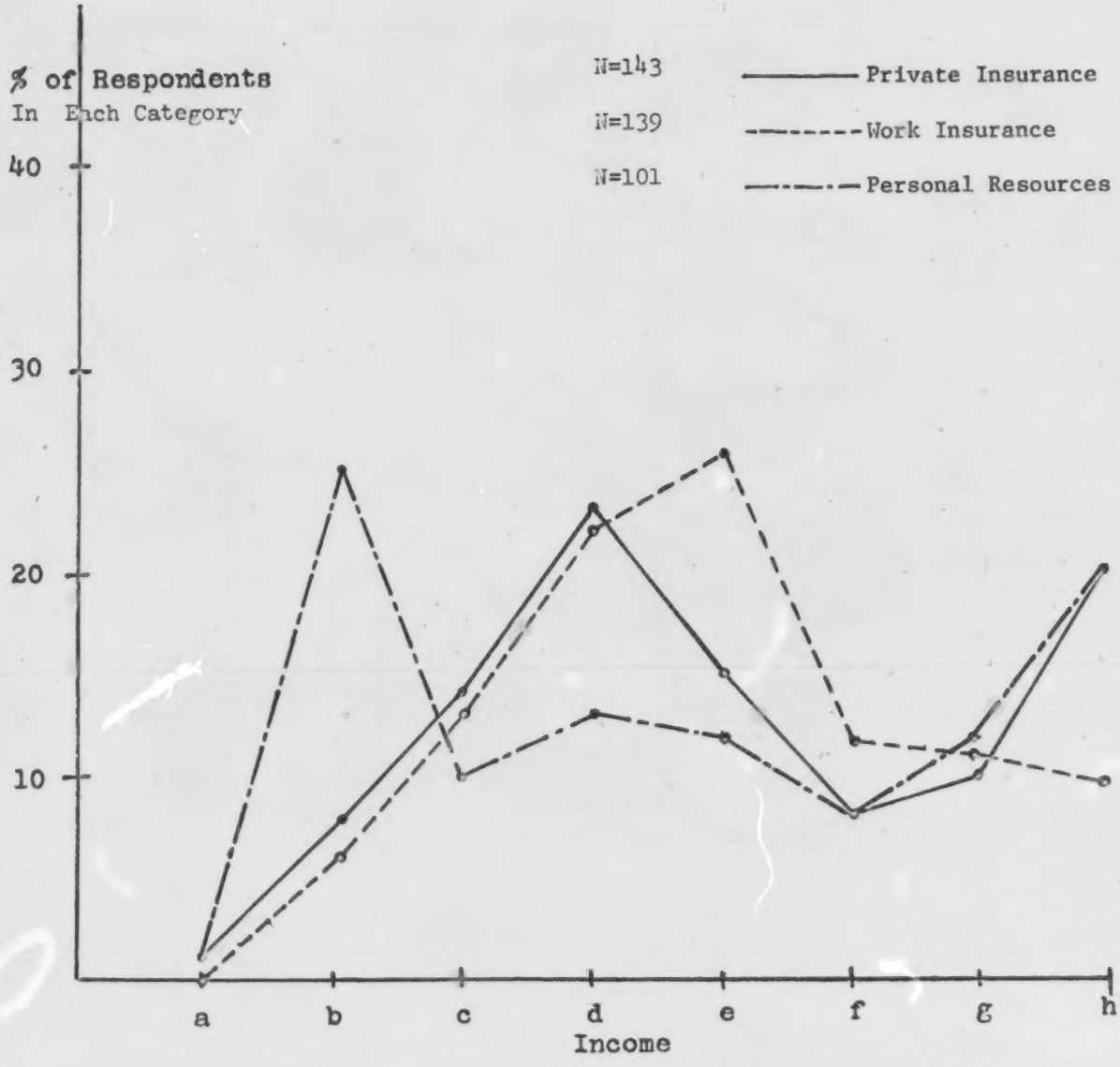
% of the number of respondents in the sample expected to use nearest population health center

% of the number of respondents actually using nearest population health center

*Note: Sample numbers were not equal for each population center.

Figure 2
(1 of 3)

FINANCIAL HEALTH PROTECTION BY HOUSEHOLD INCOME

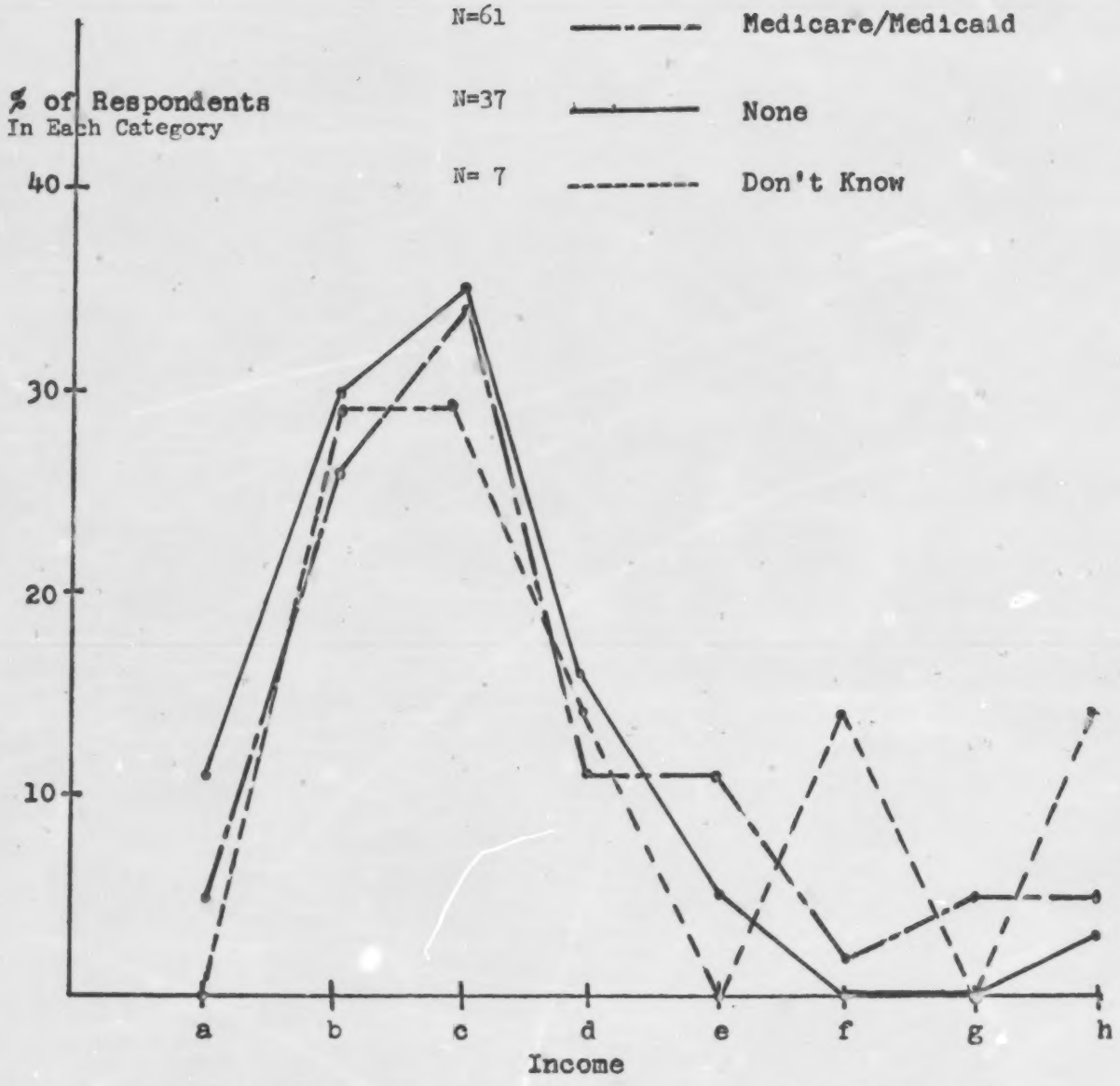


a. Under $1,000 year
b. $1,001-3,000
c. $3,001-5,999
d. $6,000-8,999
e. $9,000-12,000
f. $12,001-15,000
g. $15,001-20,000
h. Over $20,000

Figure 2
(2 of 3)

48

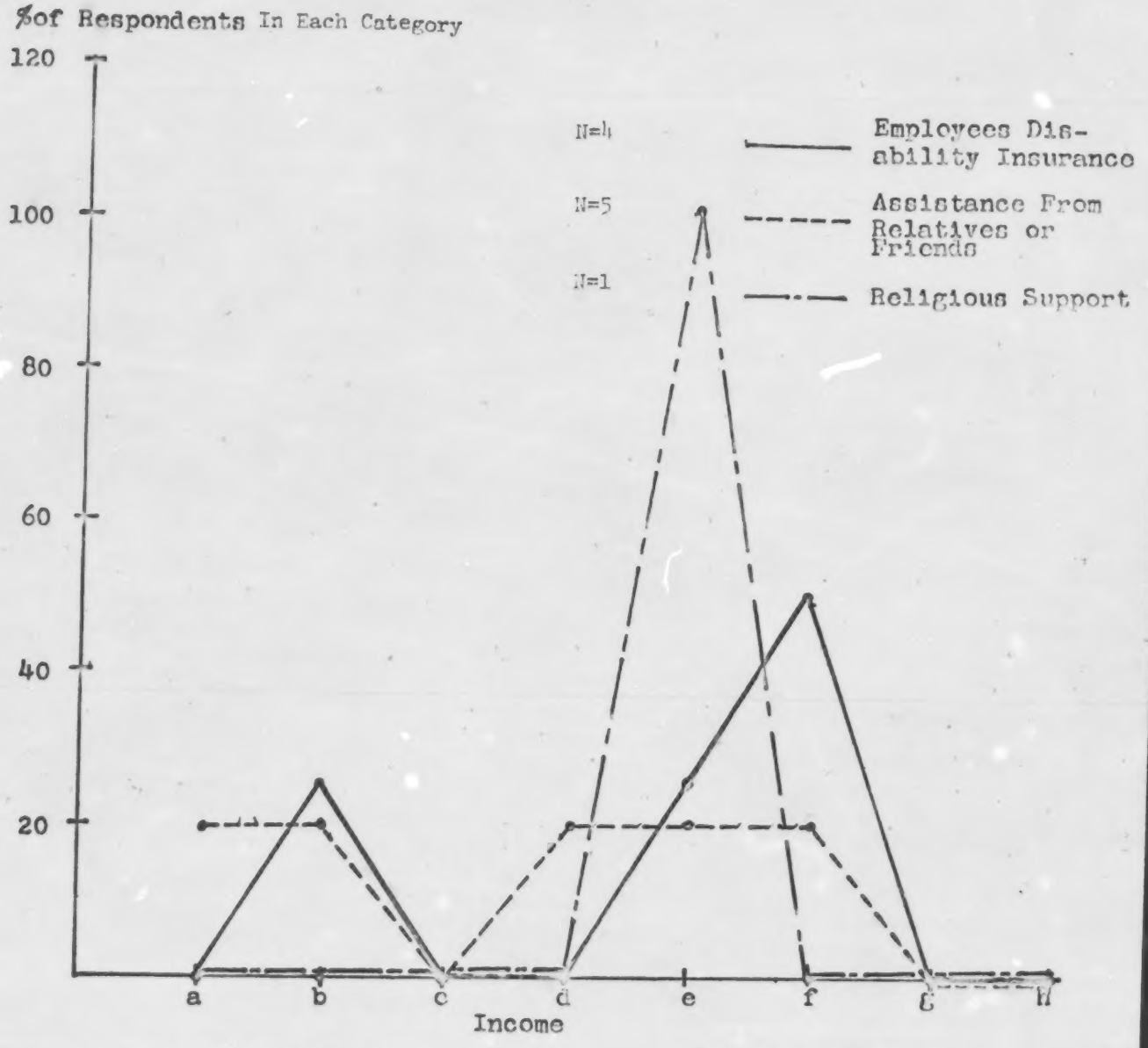
FINANCIAL HEALTH PROTECTION BY HOUSEHOLD INCOME



a. Under $1,000 year
b. $1,001-3,000
c. $3,001-5,999
d. $6,000-8,999
e. $9,000-12,000
f. $12,001-15,000
g. $15,001-20,000
h. Over $20,000

Figure 2
(3 of 3)

FINANCIAL HEALTH PROTECTION BY HOUSEHOLD INCOME



a. Under $1,000
b. $1,001-3,000
c. $3,001-5,999
d. $6,000-8,999
e. $9,000-12,000
f. $12,001-15,000
g. $15,001-20,000
h. Over 20,000

Figure 3

HOUSEHOLD HEALTH ASSESSMENT BY REPORTED NEED FOR MORE HEALTH EDUCATION/TRAINING

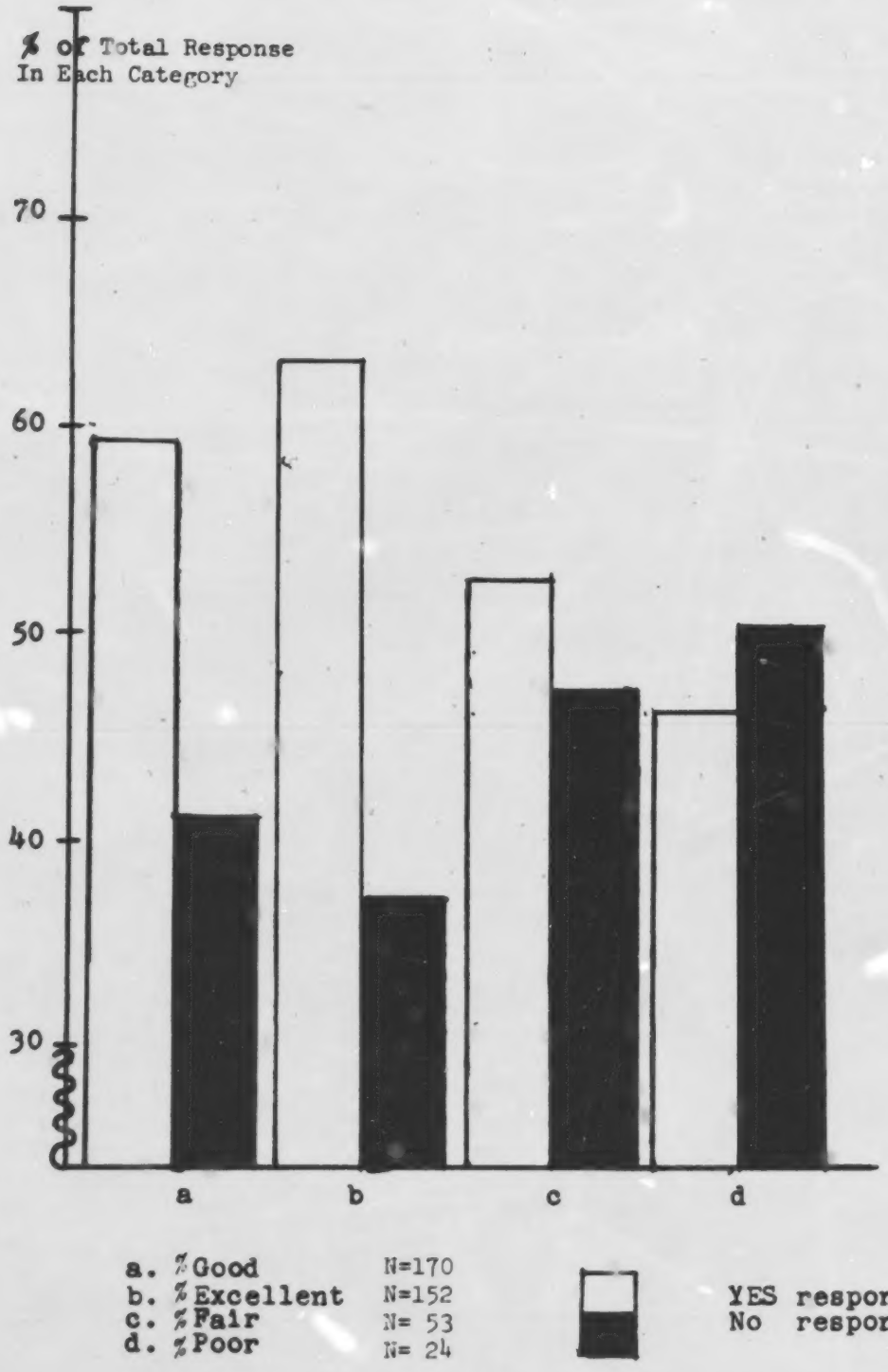
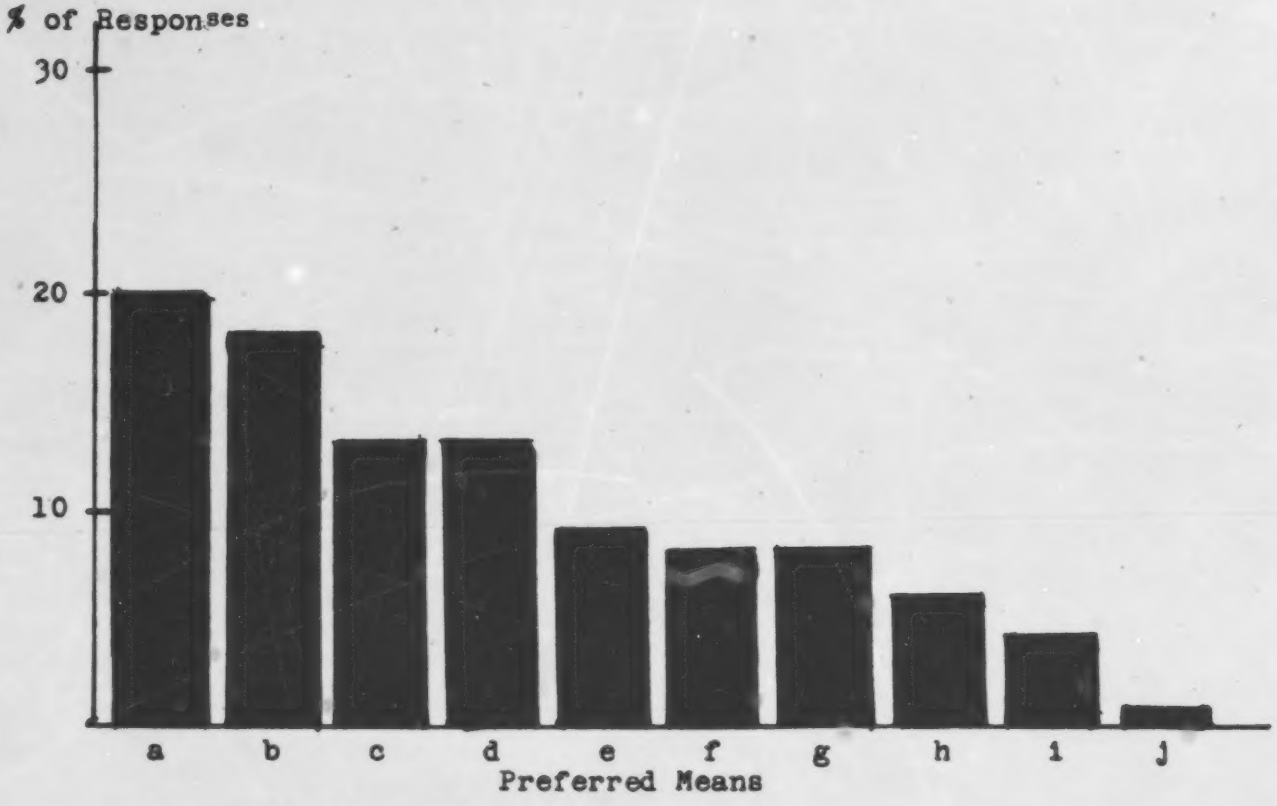


Figure 4

HOUSEHOLDS REPORTING NEED FOR MORE HEALTH EDUCATION TRAINING BY PREFERRED MEANS OF EDUCATION 51

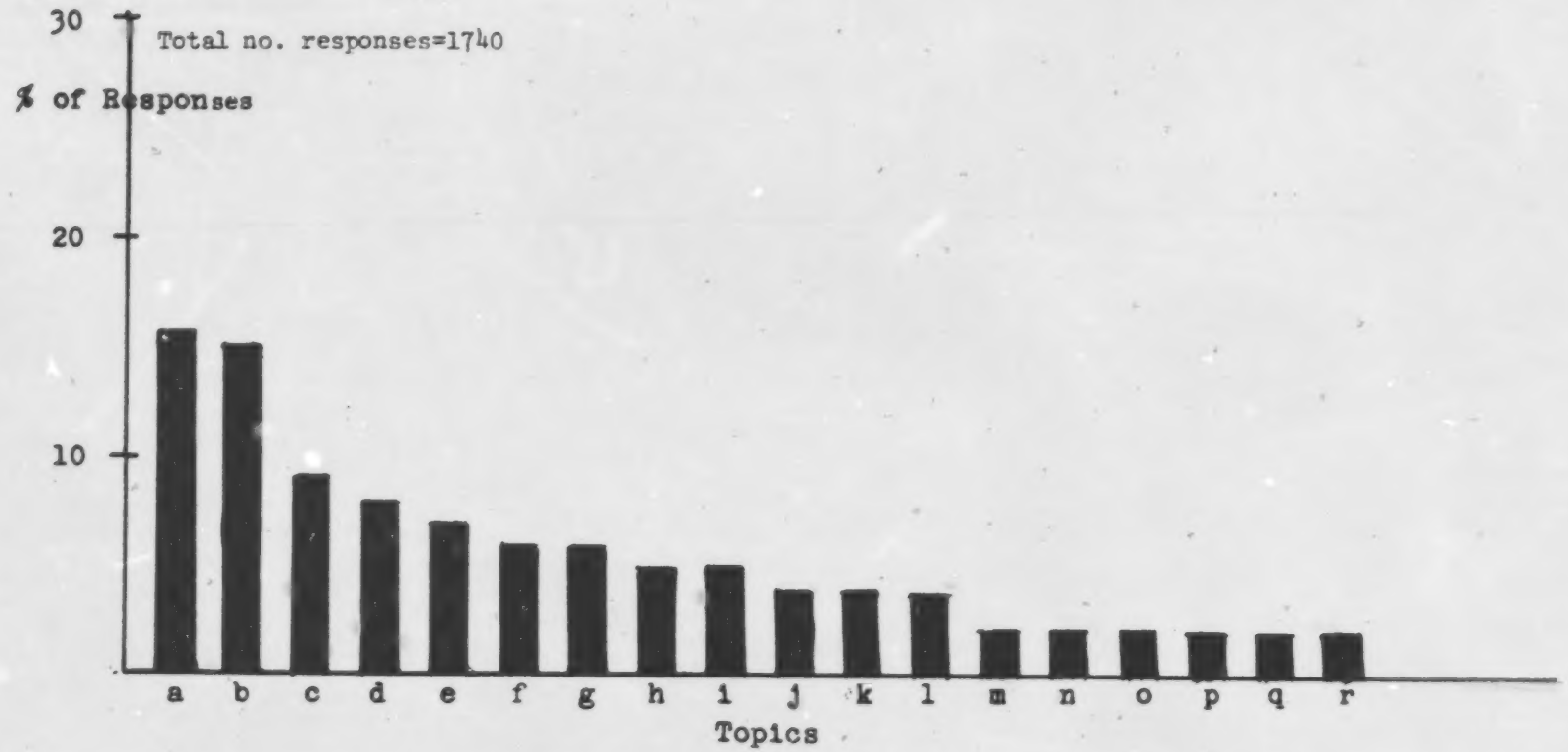
Total no. responses=1026



a. Television and radio
b. Adult education courses
c. Newspapers and magazines
d. Special literature and pamphlets
e. Talks with friends or relatives
f. Educational movies
g. Contact at home by voluntary or public health organization workers
h. Lectures and discussions with people
i. Mobile educational van
j. Other

Figure 5

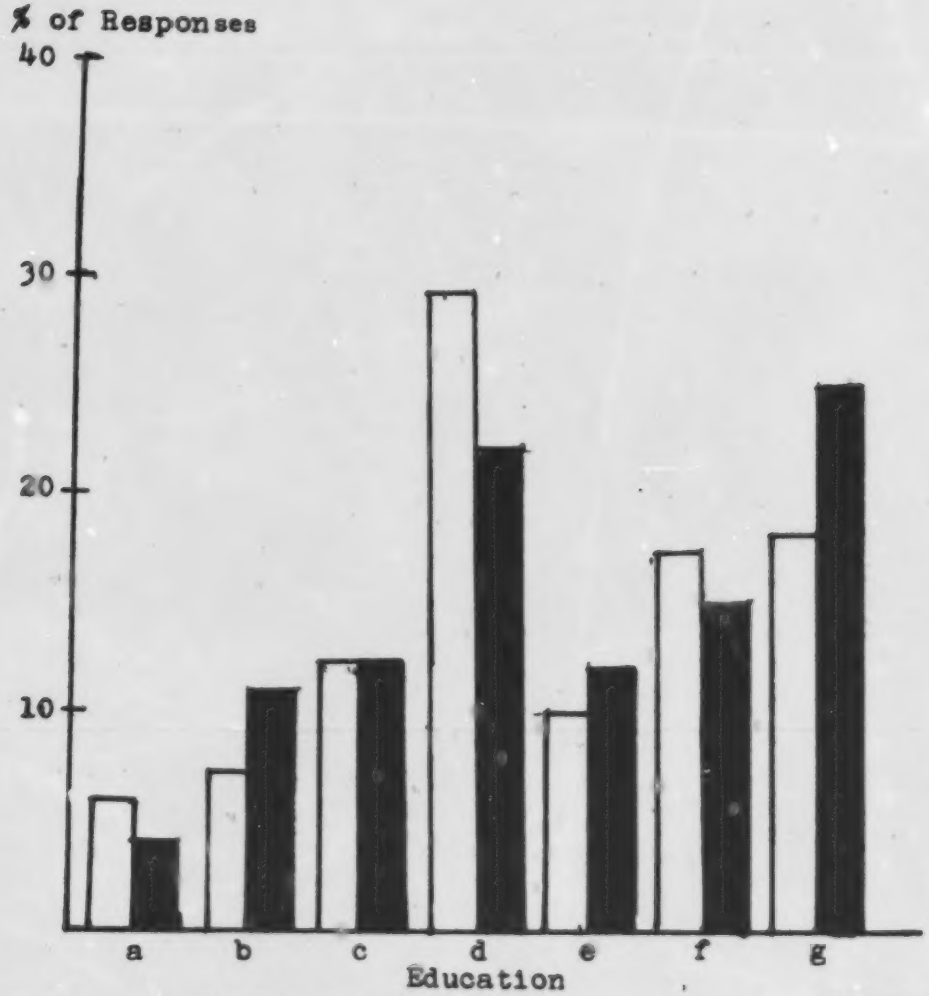
HOUSEHOLDS REPORTING NEED FOR MORE HEALTH EDUCATION/TRAINING BY REPORTED TOPICS TO BE INCLUDED



a. General household health care
b. Emergency first aid
c. Homemaker, home nursing skills
d. Health care for elderly people
e. Dental hygiene
f. Follow-up care after illness
g. Nutrition (meal planning, diets)
h. Disaster training (floods, fires, tornados, etc.)
i. Infant and child care
j. Family planning (birth control)
k. Sanitation household practices (garbage, waste disposal)
l. Other
m. Animal control and health
n. Insect control
o. Understanding and rehabilitation for military veterans
p. Prenatal care
q. Health problems for migrant workers
r. Services for the handicapped (including speech and hearing impairments)

Figure 6

REPORTED NEED FOR MORE HEALTH EDUCATION TRAINING BY EDUCATION OF HOUSEHOLD HEAD



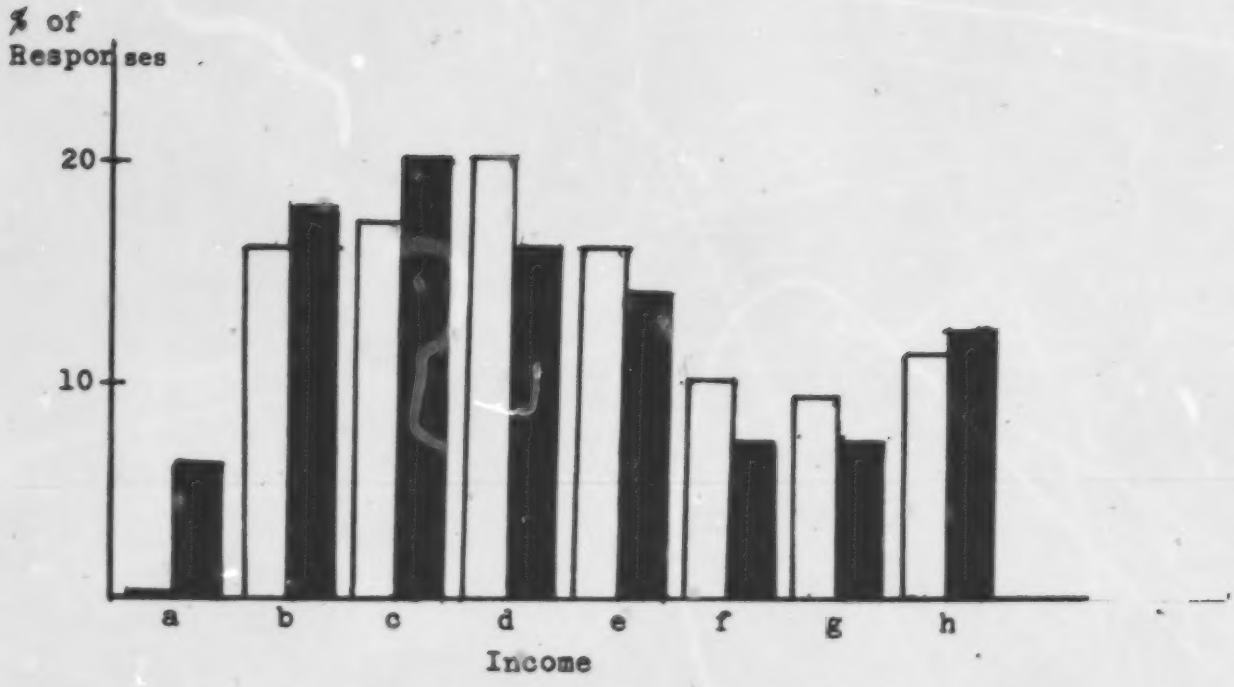
a. Professional
b. Four Year College Graduate
c. One-Three Years College
d. High School Graduate
e. Ten-Eleven Years School
f. Seven-Nine Years School
g. Under Seven Years School

% of YES responses N=226

% of NO responses N=155

Figure 7

REPORTED NEED FOR MORE HEALTH
EDUCATION/TRAINING BY HOUSEHOLD INCOME



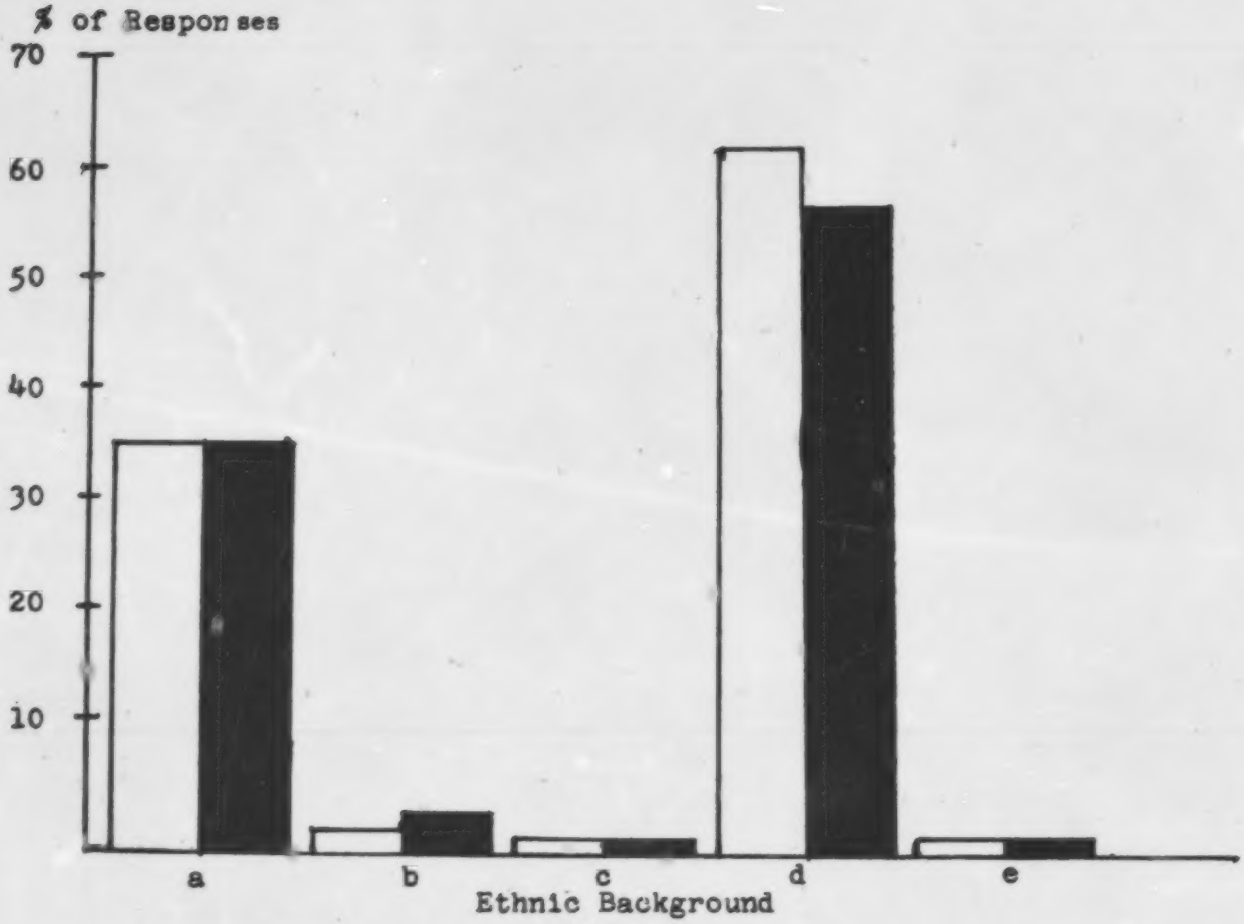
a. Under $1,000 year
b. $1,001-3,000
c. $3,001-5,999
d. $6,000-8,999
e. $9,000-12,000
f. $12,001-15,000
g. $15,001-20,000
h. Over $20,000

% of YES responses
N=229

% of NO responses
N=159

Figure 8

REPORTED NEED FOR MORE HEALTH EDUCATION TRAINING BY ETHNIC BACKGROUND OF RESPONDENT



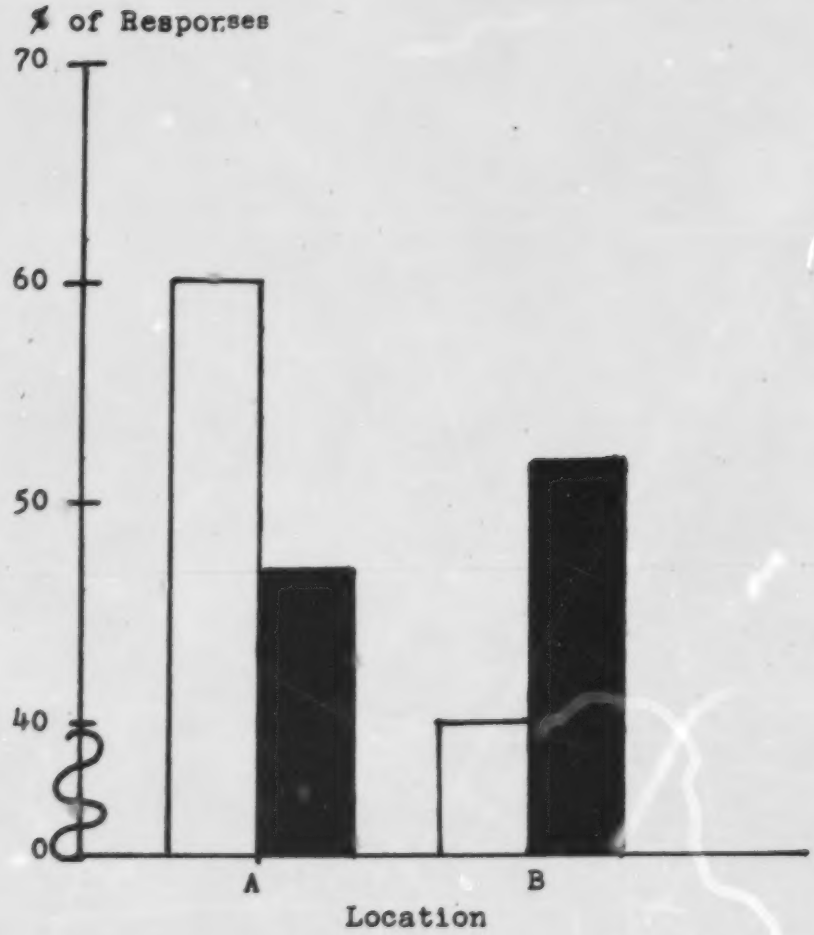
a. Spanish or Mexican-American Mexican
b. Indian
c. Black
d. Anglo
e. Other

% of YES responses N=234

% of NO responses N=165

Figure 9

REPORTED NEED FOR MORE HEALTH EDUCATION TRAINING BY RESIDENCE LOCATION



A. Rural

% of YES responses

N=235

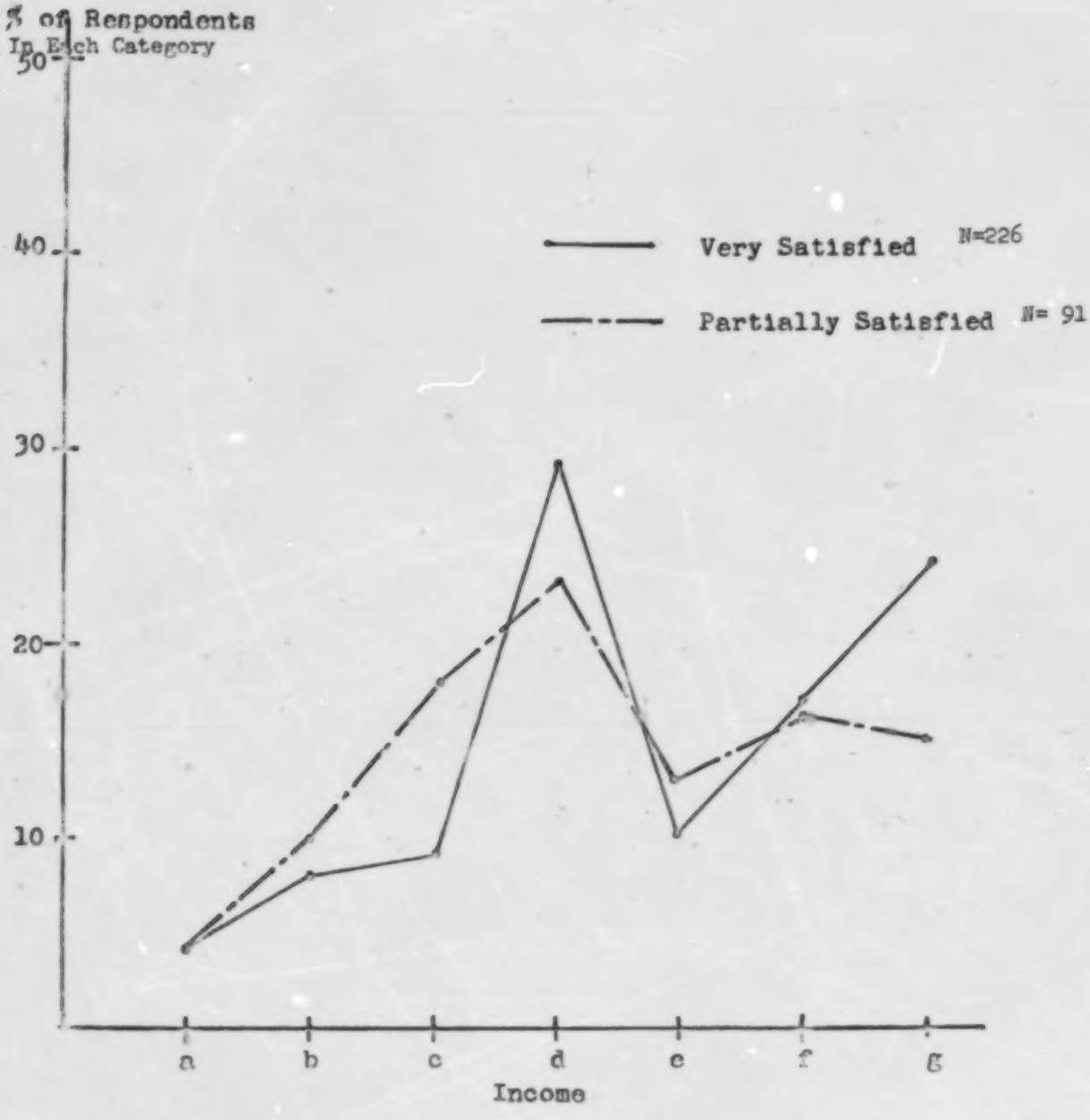
B. Urban

% of NO responses

N=165

Figure 10
(1 of 2)

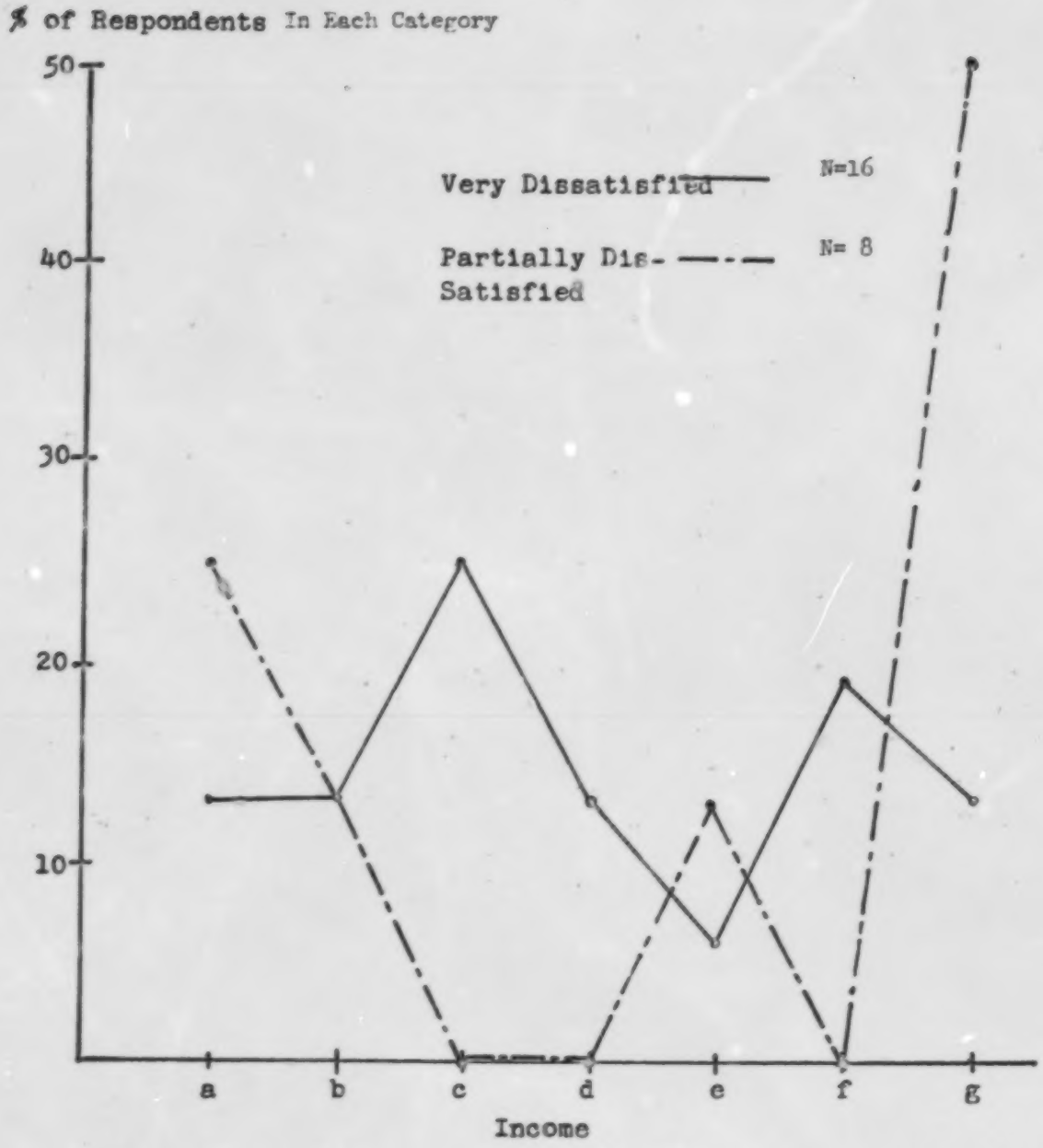
HOUSEHOLD SATISFACTION WITH HEALTH
SERVICES/CARE RECEIVED BY EDUCATION OF HOUSEHOLD HEAD



a. Professional
b. Four Year College Graduate
c. One-Three Years College
d. High School Graduate
e. Ten-Eleven Years School
f. Seven-Nine Years School
g. Under Seven Years School

Figure 10
(2 of 2)

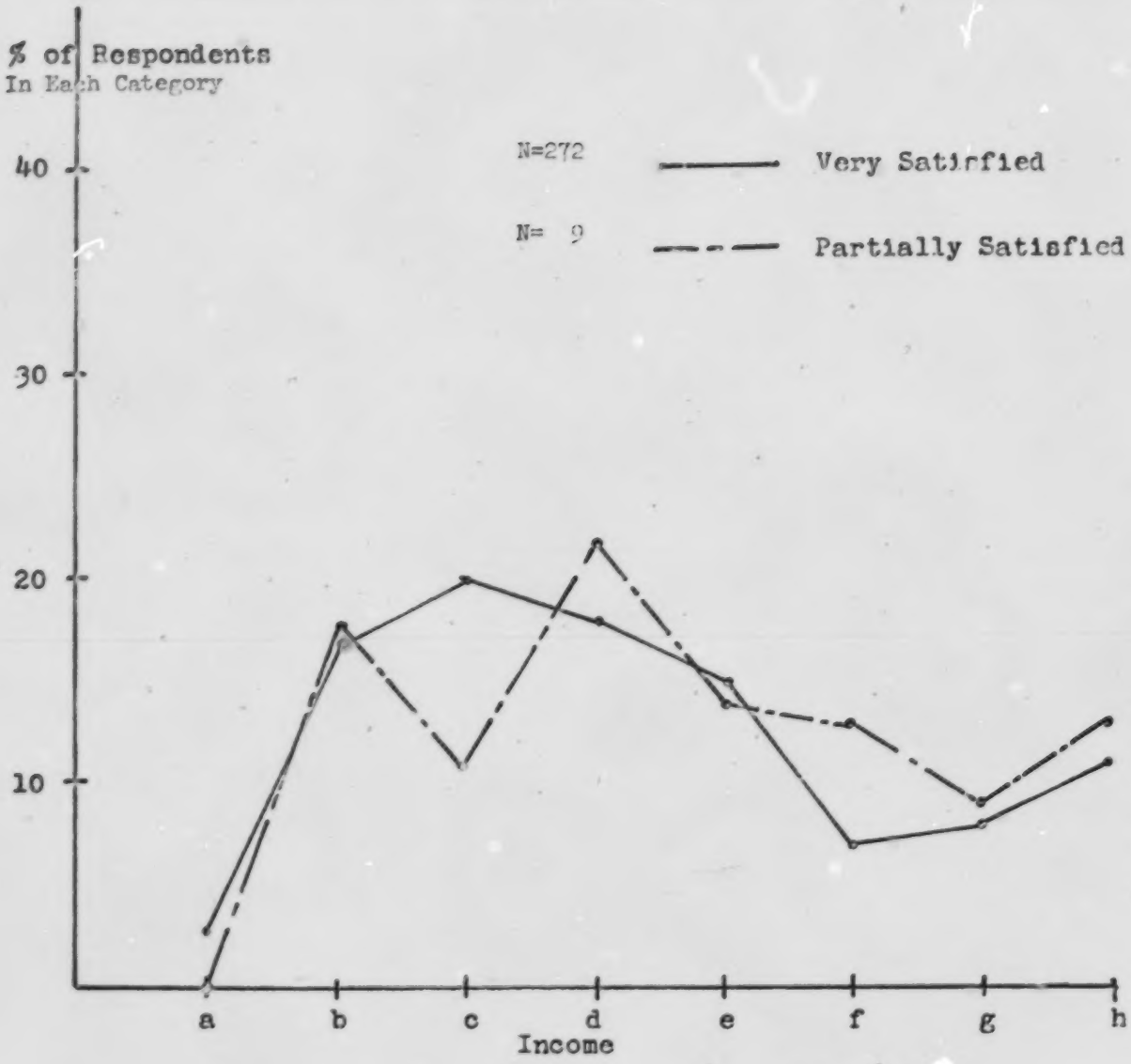
HOUSEHOLD SATISFACTION WITH HEALTH
SERVICES/CARE RECEIVED BY EDUCATION OF HOUSEHOLD HEAD



a. Professional
b. Four Year College Graduate
c. One-Three Years College
d. High School Graduate
e. Ten-Eleven Years School
f. Seven-Nine Years School
g. Under Seven Years School

Figure 11
(1 of 2)

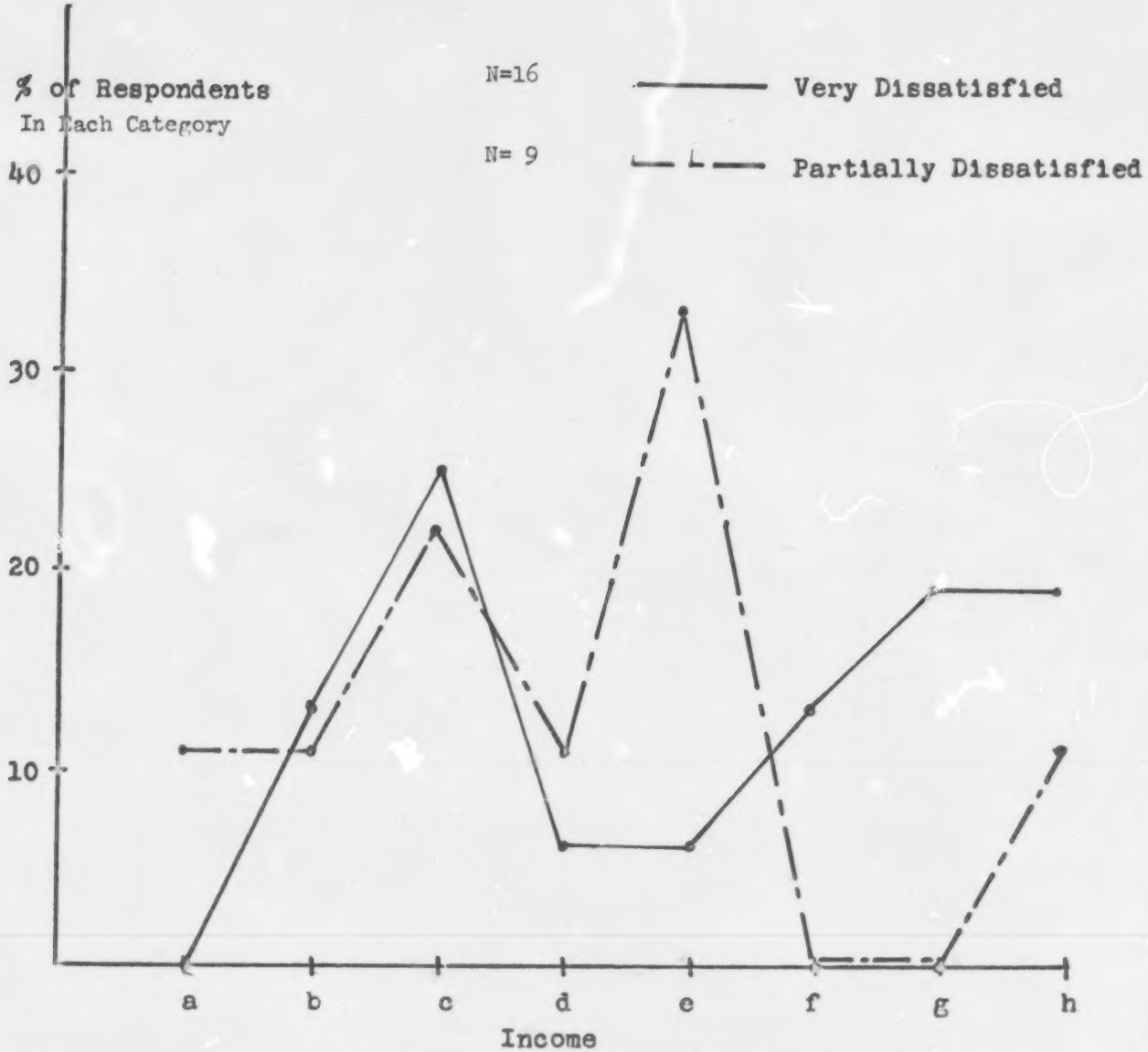
HOUSEHOLD SATISFACTION WITH HEALTH SERVICES
CARE RECEIVED BY HOUSEHOLD INCOME



a. Under $1,000 year
b. $1,001-3,000
c. $3,001-5,999
d. $6,000-8,999
e. $9,000-12,000
f. $12,001-15,000
g. $15,001-20,000
h. Over $20,000

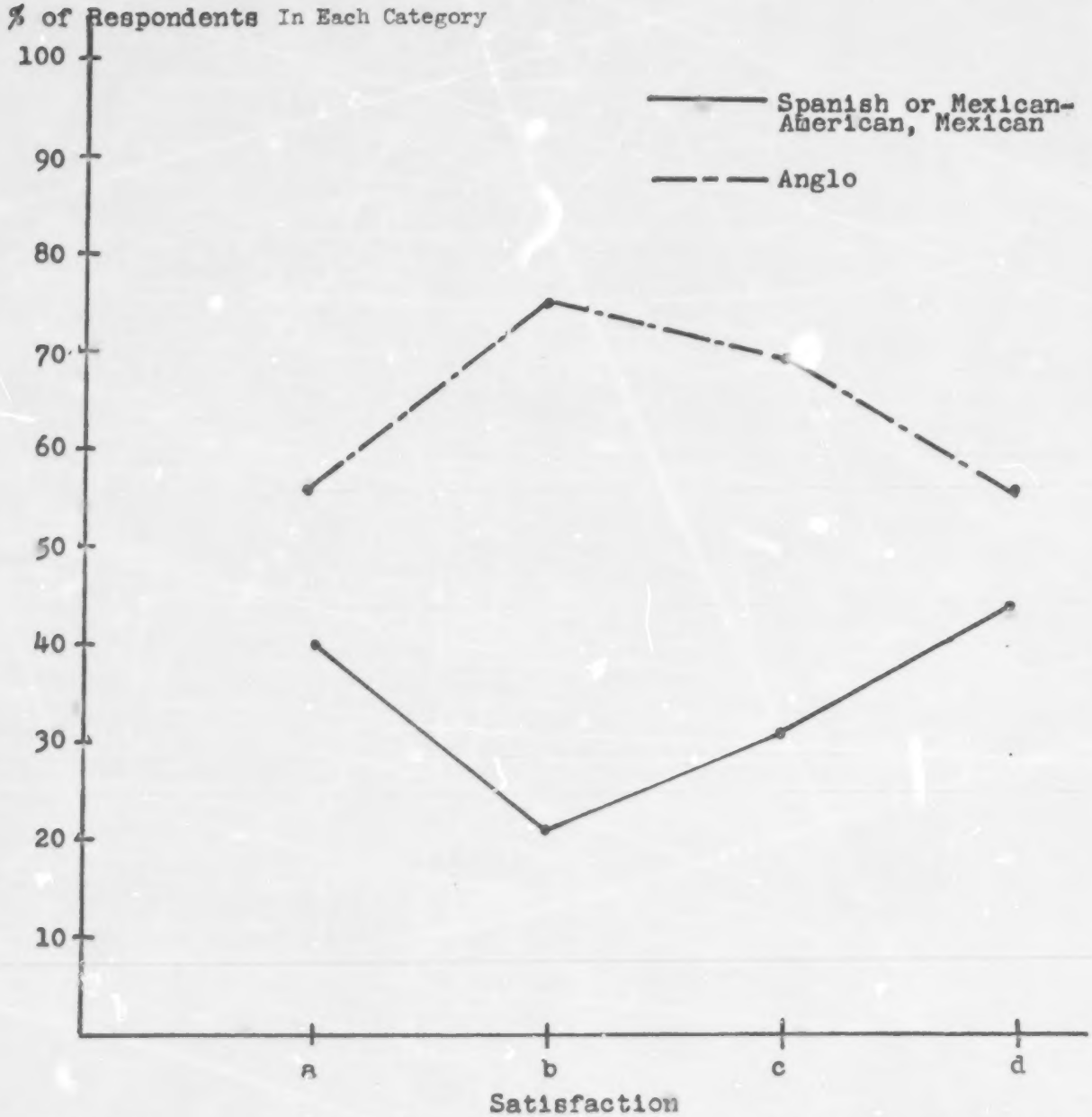
Figure 11
(2 of 2)

HOUSEHOLD SATISFACTION WITH HEALTH SERVICES
CARE RECEIVED BY HOUSEHOLD INCOME



a. Under $1,000 year
b. $1,001-3,000
c. $3,001-5,999
d. $6,000-8,999
e. $9,000-12,000
f. $12,001-15,000
g. $15,001-20,000
h. Over $20,000

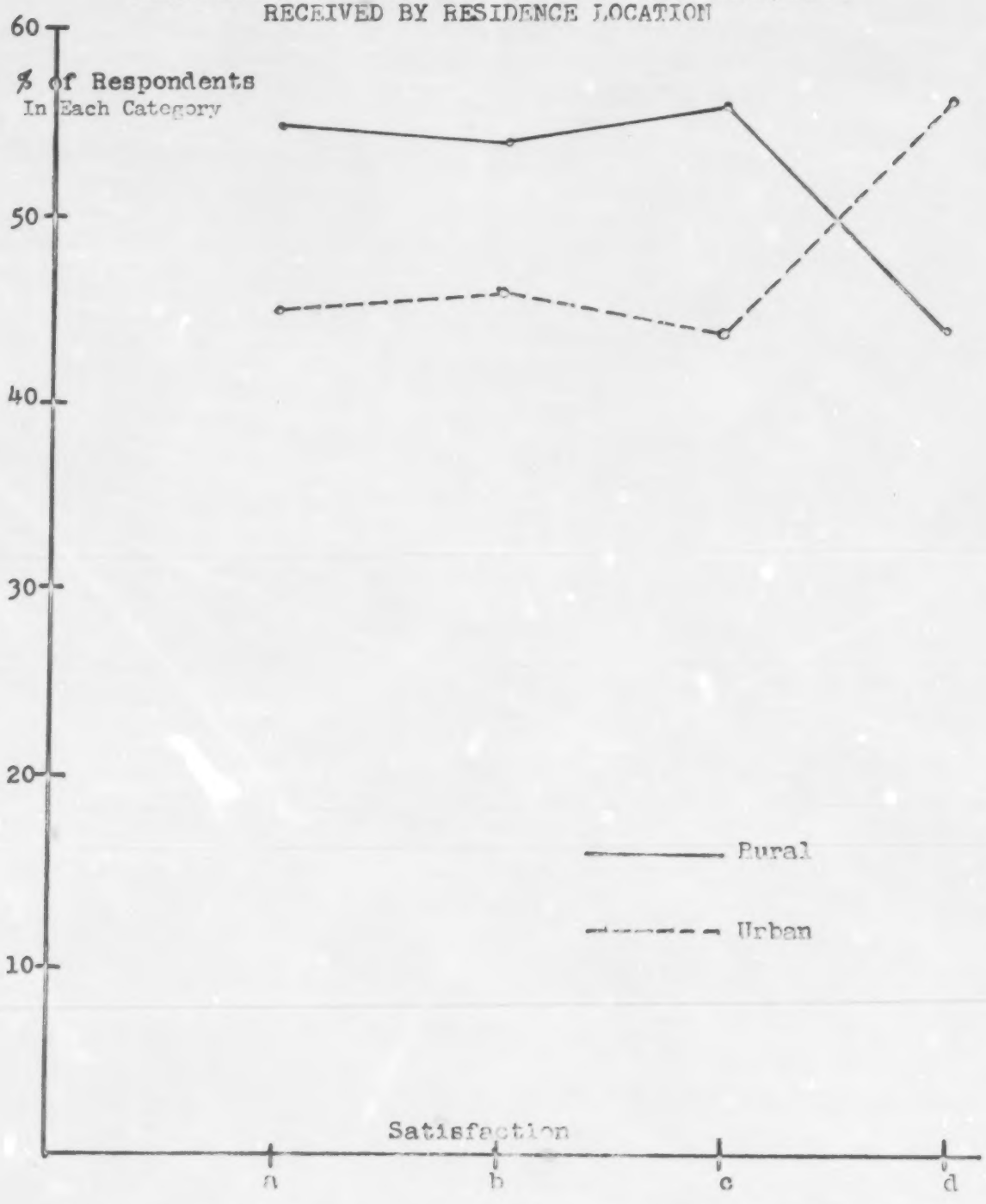
HOUSEHOLD SATISFACTION WITH HEALTH SERVICES
CARE RECEIVED BY ETHNIC BACKGROUND OF RESPONDENT



N=281 a. Very Satisfied
N= 92 b. Partially Satisfied
N=16 c. Very Dissatisfied
N= 9 d. Partially Dissatisfied

Figure 13

HOUSEHOLD SATISFACTION WITH HEALTH SERVICES/CARE
RECEIVED BY RESIDENCE LOCATION



N=281a. Very Satisfied
N= 92b. Partially Satisfied
N=16 c. Very Dissatisfied
N= 9 d. Partially Dissatisfied

III C

RURAL-URBAN RESULTS FOR ENHANCING USE OF HEALTH MANPOWER, FACILITIES, TREATMENT FOR CONDITIONS, DIAGNOSTIC SERVICES, PREGNANCY, PRENATAL, POSTNATAL SERVICES*

Among respondents reporting recommended changes for enhancing use, consortium results are reported as they apply to rural and urban household location. This distinction provides a larger numerical base than a county to county comparison. Nevertheless, the total number of responses, and reference to a particular item within a category, is limited.

RURAL SUGGESTIONS, HEALTH MANPOWER:

M.D. FAMILY DOCTOR (Exhibit V_1)

The most frequently mentioned need was an increase in manpower ("doctors not available when needed; should not have to wait so long to be seen"). Perceived difficulties in the physician-client relationship were mentioned as the second highest percentage ("does not take enough interest, need more dedicated doctor").

M. D. SPECIALIST (Exhibit V_1)

Additional experience, improved communication with and counseling of patients, and a better attitude were reported as perceived needs.

OSTEOPATH (Exhibit V_2)

Need for a more thorough examination was mentioned most frequently.

CHIROPRACTOR (Exhibit V_2)

More attention to the patient was mentioned as a category for improvement ("should not be in a hurry; exam is very superficial' appears to be in a hurry to get to the next patient").

MIDWIFE (Exhibit V_2)

One response to this category mentioned a need for assistance from a younger person.

*Responses were obtained from unstructured or "open end" questions.

DENTIST (Exhibit V_2)

Reduced cost of services was reported as the most frequent suggestion. Also, a secondary concern was a reported need for more dentists.

OPTOMETRIST (Exhibit V_3)

Use of this manpower category resulted in a suggestion for improved quality of treatment (3% of responses).

OPHTHALMOLOGIST (Exhibit V_3)

An increase in the number of these specialists was the only specified suggestion for improvement.

DRUGGIST (PHARMACIST) (Exhibit V_3)

A need for reduced cost was mentioned for this category. Also, a need to use generic rather than brand names in filling prescriptions.

NURSE (Exhibit V_3)

One respondent reported that the scope of a nurse's duties should include child treatment.

PHYSICIAN'S ASSISTANT/PARAPROFESSIONAL (Exhibit V_4)

One response indicated a need for more experienced personnel.

URBAN SUGGESTIONS, HEALTH MANPOWER:

M. D. FAMILY DOCTOR (Exhibit V_5)

Respondents indicated a need for more thorough exams ("too superficial"). Also mentioned frequently was a need for additional professional help.

M. D. SPECIALIST (Exhibit V_5)

Two responses said that specialists should provide more attention to patients.

OSTEOPATH (Exhibit V_5)

A need for improvement in discussing illness with the patients was reported.

CHIROPRACTOR (Exhibit V_6)

Need for improved patient communication was mentioned most frequently.

DENTIST (Exhibit V_6)

Needs for improved quality and reduced charges were mentioned.

DRUGGIST (PHARMACIST) (Exhibit V_6)

Need for cost reduction was mentioned in relation to this category.

RURAL SUGGESTIONS, FACILITIES:

CITY, COUNTY, COMMUNITY HOSPITAL (Exhibit V_8)

Need for increased staff was mentioned as well as reduced charges for services.

NEIGHBORHOOD OR POPULATION CENTER HEALTH CLINIC (Exhibit V_8)

A need for reduced patient cost and better staff organization was specified.

DRUGSTORE (Exhibit V_9)

Reduced cost of medicine and health-care items was a reported need.

PHYSICIAN, DENTIST OFFICE (Exhibit V_9)

A need for additional office staff was reported.

HOSPITAL EMERGENCY ROOM (Exhibit V_9)

Needs for faster, quality, efficient services , and less waiting were frequently mentioned for this category.

URBAN SUGGESTIONS, FACILITIES:

CITY, COUNTY, COMMUNITY HOSPITAL (Exhibit V_{10})

Urban residents reported a need for upgrading staff personnel as well as improving hospital organization.

PHYSICIAN, DENTIST OFFICE (Exhibit V_{11})

Elimination of overcrowding was specified as an important need.

HOSPITAL EMERGENCY ROOM (Exhibit V_{12})

Less waiting time, increased patient attention, improved management, and cleanliness of facilities were specified as needs.

CONDITIONS FOR TREATMENT, RURAL HOUSEHOLDS:

ACCIDENTS/BROKEN BONES (Exhibit V_{13})

Additional personnel and better quality of treatment for such conditions were mentioned as needs.

MAJOR SURGERY (Exhibit V_{14})

Reduced cost was specified as a need.

OUT-PATIENT LABORATORY WORK (Exhibit V_{14})

A reported need for less expensive services was mentioned.

CHIROPRACTIC ADJUSTMENTS (Exhibit V_{14})

The need for more thorough treatment received multiple mention.

TOOTHACHE/TOOTH REPAIR (Exhibit V_{15})

Cost reduction of services was specified as a major need.

CONDITIONS FOR TREATMENT, URBAN HOUSEHOLDS:

ACCIDENTS/BROKEN BONES (Exhibit V_{17})

Improved service was mentioned as a need ("assistance when a patient is trying to eat or bathe").

TOOTHACHE/TOOTH REPAIR (Exhibit V_{18})

A need for more reasonable treatment prices was stated.

PREVENTATIVE SERVICES, RURAL:

ANNUAL OR REGULAR PHYSICAL EXAMINATION (Exhibit V_{19})

A need for more thorough examination was reported ("spend more time with patient, too much of a hurry on the doctor's part").

PREVENTATIVE SERVICES, URBAN:

DIAGNOSTIC (Exhibit V_{19})

A need for a closer doctor/patient relationship was stated.

PRENATAL, POSTNATAL, AND CHILD HEALTH CARE, RURAL:

PRENATAL SERVICES (Exhibit V_{20})

Need for a pediatrician in Alamogordo was mentioned.

PRENATAL, POSTNATAL, AND CHILD HEALTH CARE, URBAN:

CHILD HEALTH CARE: (Exhibit V_{20})

Needs for pediatric services and a pediatrician were stated.

III D

RURAL, URBAN RESULTS
SUMMARY OF REPORTED CHANGES FOR ENHANCING USE OF HEALTH MANPOWER, FACILITIES, TREATMENT FOR CONDITIONS, DIAGNOSTIC SERVICES, PREGNANCY, PRENATAL, POSTNATAL SERVICES

No pronounced pattern of differences is apparent between rural and urban household location and suggestions for enhancing use.

HEALTH MANPOWER, RURAL HOUSEHOLDS

In summary, frequently mentioned needs for increased manpower applied to various categories (family physician, ophthalmologist, dentist). Within various manpower categories (family physician, chiropractor), a pattern of suggestions related to improvement in the professional-client relationship. The latter need might be met through inclusion of curriculum material exploring parameters and dynamics of the professional-client relationship. Also, core material in social dynamics and human relations would be applicable for public education and health manpower training.

HEALTH MANPOWER, URBAN HOUSEHOLDS

A highlight among suggestions was the need for improved communication between professional and client concerning the patient's illness (specified for osteopath and chiropractor). Also, lower charges were desired for dentists and pharmacists. Public awareness and knowledge of various drug/pharmaceutical categories and their manufacturer, wholesale, and retail pricing, would appear to fulfill an educational need.

FACILITIES, RURAL HOUSEHOLDS

Continuing education for allied health professionals might include content material for upgrading staff organization of population center clinics and hospital emergency room services.

FACILITIES, URBAN HOUSEHOLDS

Similar to reports of rural households, urban residents reported a need for improved emergency room services. Continuing education and training of emergency room personnel could address this topic. Also,

health manpower education and training of hospital personnel could be modified, redirected, or established for upgrading the quality of available categories of hospital personnel.

CONDITIONS FOR TREATMENT, RURAL HOUSEHOLDS

Need for reduced costs of major surgery, dental work, and outpatient laboratory work were reported. A public education curriculum for health care could include presentations by professionals and discussions with consumers regarding the need for professional services and cost explanations.

CONDITIONS FOR TREATMENT, URBAN HOUSEHOLDS

Needs reported were similar to those specified among rural respondents.

PREVENTATIVE SERVICES, RURAL HOUSEHOLDS

Increased patient attention and improvement of the professional-client relationship were reported in the annual physical exam category.

PREVENTATIVE SERVICES, URBAN HOUSEHOLDS

A need for a closer doctor/patient relationship concerning use of diagnostic services was specified.

PRENATAL, POSTNATAL, AND CHILD HEALTH CARE, RURAL HOUSEHOLDS

Few suggestions were reported. Mention of the need for a pediatrician in Alamogordo was made by one household.

PRENATAL, POSTNATAL, AND CHILD HEALTH CARE, URBAN HOUSEHOLDS

Need for pediatric services and a pediatrician were stated. Health manpower training of pediatric assistants might increase the capability for provision of child health care services.

III E

RESULTS OF RESIDENT DESCRIPTIONS OF NEEDED HEALTH SERVICES AND FACILITIES ACCORDING TO LOCATION OF MOST FREQUENT USE OF HEALTH SERVICES/CARE RECEIVED

The following information was obtained from reasons for satisfaction or dissatisfaction with health services/care received at the location most frequently used. Responses of very satisfied and partially satisfied were combined into the category of satisfaction. Partially dissatisfied and very dissatisfied were combined into the category of dissatisfied. The number of responses is limited so interpretation should take this into account. No noteworthy differences are apparent between rural and urban reasons.

ALAMOGORDO (Exhibit S_2)

Among the 64 total respondents who mentioned one or more reasons, all but nine responses indicated satisfaction for both rural and urban residents using Alamogordo. Prompt attention, good results, and faith in the physician were given as important reasons for satisfaction.

Reasons for dissatisfaction included lack of doctors, need for more patient concern, and provision of improved health-care facilities in general.

DEMING (Exhibit S5)

A total of 24 respondents mentioned reasons for satisfaction or dissatisfaction with health services/care received in Deming. Twenty reasons mentioned for satisfaction included little need for medical attention but good service when required, cordial physicians, and long standing acquaintance with physicians.

Reasons for dissatisfaction focused on a reported need for more family physicians and M.D. specialists and an increased number of general health related quality facilities. Specific mention was made of a need for a urologist and X-ray service in Deming.

LAS CRUCES (Exhibit S7)

In total, 58 reasons expressing satisfaction were recorded versus 33 responses indicating dissatisfaction. Positive remarks mentioned were satisfaction with patient attention, doctors perceived as "good", and patient needs are taken care of by existing services and facilities.

Negative evaluations focused upon the expense of physicians and other aspects of medical care, reported dissatisfaction with competency of local physicians, and confusion at the hospital in deciding what to do with the patient.

LORDSBURG (Exhibit S6)

A limited number of responses concerning satisfaction indicated needs were being taken care of. In contrast, the limited number of responses of dissatisfaction mentioned a need for a physician specialist, improved physician communication with the patient, and closer supervision of health care assistants (paraprofessionals) for "maximum efficiency."

SILVER CITY (Exhibit S12)

Twenty-one satisfied responses were reported for use of services including good patient attention and good services ("the doctors for Kennecott are excellent and give us good medical attention"). Approximately the same number of negative responses were recorded including excessive cost of medical care and too few family physicians and specialists. Dentist and doctors offices were said to be poor facilities and too crowded for the office size. The appointment process for dentists and physicians was reported as too arduous. A mention was made of the need for a pathologist.

SOCORRO (Exhibit S14)

Fewer satisfactory responses than dissatisfactory were recorded although the total number of responses was limited. Reasons for satisfaction included doctor house calls and little difficulty in obtaining medical services. Dissatisfaction centered around the specified need for more physicians, including specialists. Overcrowded dentist and physician offices were reported and a need for better health-care facilities (hospitals, offices,etc.).

TRUTH OR CONSEQUENCES (Exhibit S15)

Those respondents with favorable health service comments said they were seldom ill. Unfavorable comments specified need for more thorough physician examinations and more time with patients. Also mention was made of poor hospital organization resulting in too much confusion.

WHITE SANDS (Exhibit S17)

Few mentions of satisfaction or dissatisfaction were made. Satisfied responses indicated treatment was "okay so far." An unfavorable response concerned reported discrimination against and delayed treatment for retired military personnel.

III

RESULTS AND DISCUSSION CONCERNING FOUR VARIABLES

The following four null hypotheses were tested:

There will be no significant difference among survey respondents in responses to reported household satisfaction with health/services care received according to differences in annual household income.*

There will be no significant difference among survey respondents in responses to reported household satisfaction with health/services care received according to differneces in head of household's education.

There will be no significant difference among survey respondents in responses to reported household satisfaction with health/services care received according to differences in heads of household's ethnic group.

There will be no significant difference among survey respondents in responses to reported household satisfaction with health/services care received according to residence location (rural or urban).

CHI-SQUARE TEST OF HOUSEHOLD SATISFACTION IN RELATION TO FOUR VARIABLES

Variable	Degrees of Freedom	Calculated Chi-Square	Chi-Square Value .05	Significance
Income	1	.451	3.84	Not significant
Education	1	7.014	3.84	Significant at .05
Ethnic Group	1	.076	3.84	Not significant
Residence Location	1	.006	3.84	Not significant

*In view of Potter's investigation of variables in the New Mexico health medical care situation, two discrete categories of income were used for the chi square test as a product of combination, lower income and moderate income. Two discrete categories of the variable of education were used (professional and non-professional). Also, the discrete categories of rural or urban were used for the variable of residence location. For the variable of ethnic group background, the two groups of Anglo and Mexican-Americans were used. Two discrete categories of satisfaction or dissatisfaction were used in the contingency table.

From the above table it can be determined that the null hypotheses of no significant differences among survey respondents in responses to reported household satisfaction with health/services care received according to the variables of annual household income, heads of household's ethnic group, and residence location are accepted. That is, these variables were determined to be independent of reported household satisfaction.

In contrast, the null hypothesis of no significant difference among survey respondents in responses to reported household satisfaction with health/services care received according to differences in head of household's education is rejected. The variable of head of household's education was apparently correlated with differences in reported household satisfaction with health/services.

Results from the literature examined concerning health/services care use and the variable of education were ambivalent. Also, the null hypothesis in the study included the conceptual social psychological link of health/services care use as an important component of evaluation (satisfaction/dissatisfaction). Accordingly, a limited basis existed for predicting the expected direction of the relationship in the form of an alternative (H_1) hypothesis.

III G

IDENTIFICATION OF CONSUMER NEEDS AS REPORTED IN USAGE EVALUATIONS AND EXPRESSED SATISFACTION/DISSATISFACTION WITH HEALTH CARE SERVICES, FACILITIES, AND PERSONNEL

Information concerning usage evaluations, and reasons for satisfaction/dissatisfaction, with health services, facilities, and personnel, highlight problem areas for planning and further investigation. Results provide numerical inputs for planning but it should be recognized that in some instances the number of responses are very limited and need to be expanded through additional studies. Because of sampling in proportion to population percentage, it is reasonable to expect more comments from more heavily populated areas. The data from this survey might be used as a basis for identifying indicated topic areas of need and formulating hypotheses for additional planning studies.

In the sample of respondents, certain overall recurrent needs can be isolated and identified. These needs concern the subject areas of increased manpower, physician-client relationship, improved physician service, cost of health care and services, facilities improvement, and diagnostic/preventative services manpower and education.

The need for increased manpower (Alamogordo, Lordsburg, Deming, etc.) was primarily mentioned as it applied to the general category of physician and certain specified physician specialties(pediatricians, ophthalmologist).

A second general area of need is the physician-client relationship. Frequent mention (Alamogordo, Lordsburg, etc.) was made of the need for improved communication and patient counseling, particularly concerning diagnosis and treatment. Also, some persons reportedly perceived a lack of interest, concern, and attention among contemporary physicians versus the physician of the "good old days."

Third, mention of the need for improved service (Socorro, Truth or Consequences, etc.) focused again on the physician category. Patients frequently mentioned that physicians needed to be more thorough in their treatment, spend more time in examining patients, and improve their treatment results. Family physicians, osteopaths, chiropractors, and optometrists were mentioned. It is interesting to note that the training professional categorization of the latter three groups has been the subject of discussion and varying interpretation among peers in the health care professions.

Fourth, the cost of pharmacist related services (drugs), dental repair, hospital services, physician treatment, and other health care services is reported as excessive and in some instances out of the reach of the "common man" (Las Cruces, Silver City, etc.).

Fifth, among health related facilities, some physician and dentist offices (Alamogordo, Silver City, etc.) reportedly need to be improved in the quality of the physical facilities as well as increased in size ('too crowded'). The aspect of office size might also relate to a high volume patient load. In addition, unspecific mention of some hospital emergency rooms involved their unsanitary conditions, required patient waiting time, and shortage of staff. Moreover some community hospitals were stated as needing better management and organization to avoid patient confusion and upgrade their services and staff quality.

Sixth, diagnostic and preventative services/manpower needs were ascertained by respondent mention and analysis of the data which indicate their limited use. As previously mentioned, results reveal a lack of knowledge concerning the value of preventative services such as innoculation and balanced nutrition. Diagnostic services, particularly those concerning pregnancy, prenatal, and child health care were mentioned as requiring more physicians (obstetrician-gynecologist, pediatrician) and allied manpower (midwives, nurses). A need for additional and/or improved education concerning use of diagnostic services is apparent in view of the reported manpower shortage.

The hierarchy of needs with regard to priority vary some according to areas within the quadrant, but these six identifiable subject areas of need apply generally to most rural and urban locations included in the sample.

An additional need exists for determining the nature, role, and intricacies of the local power structure as interrelated to the aforementioned categories. Such a determination is critical for ensuring an understanding of local value systems, norms, and sanctions, for logical use as assets positively reinforcing the existence and identification of needs and programs for their solution.

IV

CONCLUSIONS AND RECOMMENDATIONS OF REPORTED NEEDS RELATING TO PUBLIC COMMUNITY HEALTH EDUCATION AND MANPOWER TRAINING

In total, the health-medical care needs of residents in the Southwestern consortium may be considered by allusion to the illustration of a financial statement. The situation relating to certain topical items in the statement, certain aspects of health-medical care needs, is favorable insofar as needs are reportedly being met in excess of a minimum required breakeven level through use of existing assets. In contrast, other items in the statement, other dimensions of health-medical care needs, are in an unfavorable position to the extent that needs are not being provided for at a minimum required breakeven level. Changes in strategy and reallocation or use of resources must be made, or additional allocations preferred, so that the latter items become future assets instead of continuing liabilities.

It is apparent that the nature and purposes of a determination of health-medical care needs and a free enterprise ledger differ to a great extent in certain respects. For area residents determination of health-medical care needs involves more than a counterbalance of assets and liabilities for an overall composite rating of success. The complexity of interrelated variables in the health-medical care subject area, and the frequent individual requirements of a situation, indicates limitations for such a computation. For health care, certain quantities are not so easily determined or measured as dollar profit or loss. Individual and social value systems are among determinants for deciding what is a breakeven point in meeting the health care needs of an individual (is it as apparent as a life-death dichotomy?) household, community, or nation. Moreover, the importance of health-medical care subject items on an imaginary ledger would differ in importance and lack standardization for individuals and households in a consortium.

Nevertheless, the allusion to a financial statement is helpful to the extent that it indicates the need for a more systematic approach to objective measurement and evaluation of health-medical care needs. Although the use of an asset-liability determination for health-medical care is complicated by certain variables, it is possible to ascertain strengths and weaknesses in the provision of resources to meet health-medical care needs. The same consumer base exists for the free enterprise system and the health-medical care system. The ideal of both systems is to provide optimal service and satisfaction for the customer. The experimental nature and current imperfectability in the field of medicine, and health care delivery, indicates a broad horizon for continuing development. It is apparent to providers and consumers, that a general need exists for improvement in quality and capability of

services and facil[illegible]provided. Also a need exists for more comprehensive cover[illegible] increased availability and equitable distribution of serv[illegible] facilities on a more informed basis. It has been determined [illegible] health-care investigators that the latter points apply to many geographical areas. These observations also apply to the Southwestern consortium of New Mexico.

Information concerning needs was obtained both indirectly from health-care services/facilities usage information and by direct response to need questions.

LOCATION

Results concerning household county location, nearest health center and most frequently used health center, are limited because of the proportional population sampling and differences in the number of completed interviews within each county. For the consortium as a unit, approximately two-thirds of households in the sample used a nearby population health center, and one-third used a major health center geographically outside of the consortium. In like manner, it should be assumed that determination of location with regard to use of existing facilities for health education and training should logically consider existing facilities, access, and distance as major factors in relation to the target population.

Greater than 60% of the population in the eight county area, a large number of health-medical services/facilities, and several existing educational facilities and buildings for potential instructional use, exist in the adjacent counties of Dona Ana and Otero. In turn, these two New Mexico counties are joined at their terminus to El Paso County, Texas. When these three counties are combined, a major resource triad is formed as a central point of conduct or distribution within the consortium. This area is geographically accessible and similar to the other southern counties in the consortium (Hidalgo and Luna).

Such a major sub-area creates an imaginary line for a second major or northern sub-area as a focal point for conduct of programs and centralized health manpower training. Geographically, Catron, Socorro, Sierra, and Grant counties are similar in that they contain portions of remote rural mountain areas, and are reasonably accessible, in terms of distance and thoroughfares, to one another. When combined, they form a four county nucleus containing a number of health services/facilities and existing educational structures for potential training use. Demographically, this four county combination approximates one-third of the consortium population.

It is noted that the consideration of two major sub-areas, presents a workable alternative to facilitate planning and logistics for community health education and manpower training. Content of educational and training programs developed for dissemination in each of the two sub-areas would contain need components common to the consortium and any local provisions so desired. Cost and duplication of effort would be avoided through use of a single central program development committee with appointed representatives from each sub-area and all counties in the consortium.

FINANCIAL PROTECTION

To the extent that the survey sample is representative of the population of the consortium, between approximately 15-20% of heads of household in the lower income categories of under $1,000 a year, $1,001-3,000 and $3,001-5,999 are reportedly not covered by any type of financial health protection. These results represent a need for additional financial coverage among lower income groups. Community health education in this subject area should focus on the availability of public insurance and coverage for lower income individuals, as well as attitudes and motivation in relation to insurance coverage.

GENERAL HOUSEHOLD HEALTH LEVEL AND SPECIAL/RECURRENT HEALTH PROBLEMS

For the consortium, only 6% of the sample of respondents reported a poor general household health level. A larger percentage of respondents (30%) reported the existence of special/recurrent health problems among one or more household members. Apparently, the latter conditions were not perceived as warranting, or the good health of other household members offset, a poor overall rating for the household.

Among responses specifying the name of special/recurrent health problems, arthritis was mentioned by 17%, diabetes mellitus by 12%, and heart trouble by 10%. Each of these disease categories is common to the general population as well as the sample. Diabetes mellitus and heart trouble are illness categories where patient education is particularly important. The limited number of responses among the sample to the questions concerning what needs to be provided for the household to facilitate care of a person with a special/recurrent health problem, or what is needed to rehabilitate that person, could be interpreted in two ways. First, the questions might not be understood or stated well. Second, and probably more likely as indicated in the pretest, some respondents frequently lack knowledge concerning what can or should be done for an ill person.

Health manpower training of physicians, nurses, and paraprofessionals, should include a training segment focusing on how to improve the role of patient self-care for certain applicable disease categories. Education for the lay public should provide some basic knowledge fundamentals of the particular disease and what the patient can and should do to facilitate professional treatment.

For example, diabetes mellitus is asymptomatic insofar as its "characteristic" symptoms of polyphagia, polyuria, and polydipsia provide no subjective basis for disease. Moreover, the progress of a less severe but more common type of diabetes mellitus, maturity onset diabetes (prevalent among people age 40 and older), can be retarded through increased exercise regimens and diet control recommended by physicians. Patient knowledge and understanding of these facts can ease the treatment task of the physician and sometimes improve the patients prognosis. Patient self care among diabetics is particularly important with regard to bodily care of limbs, particularly protection of feet in instances of neuropathy and circulatory complications. Retinopathy, renal impairment,

and cardiovascular disorders are frequent side effects of certain types of diabetes mellitus which may be delayed or prevented through patient knowledge and realized importance of proper self care.

Manpower training for health professionals in contact with diabetics might include such topics as development and dissemination of ethnic diets, differences among classification types of diabetes mellitus and the importance of individualized treatment, and emergency measures for such occurrences as hypoglycemic reactions among insulin users.

Similar heart disease-hypertension and arthritis educational approaches could be developed for and directed to continuing education of health care professionals and education for the general public.

ETHNIC GROUPS, DISEASE CONCEPT ORIENTATION, AND THE ILLNESS PROCESS

No pronounced difference among ethnic groups in the sample was reported relative to disease concept orientation and the illness process (questions relating to most important symptoms used in determining illness and sources of influence in the illness process). It is noted that apparently a need exists in the Southwestern consortium for discussing the role of cultural differences in lay community health education and professional/paraprofessional health manpower training. Among respondents from the eight counties it would seem that differences in culture, particularly Mexican folk beliefs and propitiatory practices are not as important a factor in preference for modern medical regimes and conceptualization of the illness process, as some investigators have reported.[45] Folk medical sources of influence, and folk medicine symptoms of illness, were not reported as a first concern in 140 Mexican-American households interviewed.

A study by Nall and Speilberg reported no demonstrable impact of folk medical beliefs and practice concerning the acceptance or rejection of treatment for tuberculosis among a sample of Mexican-Americans in the lower Rio Grande Valley of Texas. Rather, a milieu effect of the Mexican-American subcommunity was demonstrated as an important factor. This milieu effect included a variety of social integration indices including investigation of the influence of relatives and friends in the neighborhood.[52]

Community health education and manpower training for professionals should create awareness of theories relating culture to health-medical care. It should be stressed that results of investigatory studies are ambivalent. Furthermore, the cultural diversity within each ethnic group, particularly Mexican-Americans, should be recognized. To this end, explanatory theories and empirical results cannot be meaningfully applied to all members of a particular ethnic group, such as Mexican-Americans. The latter are a diverse group including such sub-categories as Chicanos, Tejanos, Arizonos, and Californios. Each of these groups possess certain values which may be alike or dissimilar according to such factors as geographic location and the constellation of individual and group personality factors involved.

PREFERRED MEANS OF LEARNING MORE ABOUT HEALTH/MEDICAL CARE EDUCATION AND PREFERRED TOPICS

The highest percentage among preferred means of health-medical care education for the Southwestern consortium general public was 20% for television and radio. A need exists for development of informational programs using this medium. It should be considered that studies of the mass communication media have consistently demonstrated that those lower on the economic scale fail to obtain health and science information from the mass media to the same extent as those of higher income." Although, in terms of exposure the poor attend to health information transmitted via radio and television to about the same extent as the financially better off. These established relationships also hold for exposure to the print media. Most of the available results from studies support the proposition that knowledge of health matters and exposure to health information is associated with income even when educational attainment is controlled." The latter point indicates a need for a differential programming approach directed to target listening audiences according to household income differences. Media buyers for radio and television stations can provide a demographic profile of their listening audience overall, and according to program format. In this way, a selection procedure may be utilized to assist in providing for optimal media effectiveness as a means of consumer education. A similar approach might be utilized for printed materials. Achievement of educational objectives such as greater awareness and increased levels of knowledge, is dependent upon the interrelationship between means of providing education and subject material. Use of the broadcasting media requires topics with videspread or specialized broadcast appeal. Such a determination should be made by media experts. An example of such a broadcast might include the reported topic of disaster training or general emergency first aid relating to a potential mining disaster in the Silver City area, Grant County, New Mexico. In contrast, adult education courses are practical for treatment of more detailed and demonstration type topics (emergency first aid treatment). Controversial subjects such as birth control are more appropriate for printed matter or adult education courses. Venereal disease prevention has frequently been publicized in educational movies. Neighborhood discussion groups provide a convenient forum for sharing ideas concerning such everyday topics as homemaker skills. This technique might be particularly applicable to local community health for the general public. There is a need for consumer community health education curriculum development in the south[illegible]tium incorporating the most frequently preferred topics [illegible]):

General household health care	16%
Emergency first aid	15
Homemaker, home nursing skills	9
Health care for elderly people	8
Dental hygiene	7
Follow-up care after illness	6
Nutrition (meal planning, diets)	6
Infant and child care	5
Disaster training (floods, fires, tornadoes, etc.)	5

Family planning (birth control)	4
Sanitation household practices (garbage, waste disposal)	4
Animal control and health	3
Insect control	3
Services for the handicapped (including speech and hearing impairments)	3
Prenatal care	2
Understanding and rehabilitation for military veterans	2
Health problems for migrant workers	2

Manpower training needs in the southern consortium relate directly to consumer health education needs mentioned by respondents. Preferred topics among consumers should be integrated into continuing education for health care professionals in the manner, and to the extent, that each topic relates to the function of each professional category and their provision of services. Manpower training for these groups needs to be more intensive, thorough, organized, and controlled versus health education for the public.

Manpower training for a newly proposed category of health professional, such as a regional community health liaison and program development specialist needs to be evolved in view of job objectives and specifications relating directly to such expressed needs as have been discussed.

HOUSEHOLD NEED FOR MORE HEALTH EDUCATION/TRAINING

Fifty-nine percent of the respondents interviewed expressed a need for more health education/training in the Southwestern consortium.

Need for more education was reported as greatest among heads of household with a high school education and those with less than seven years of school. According to household income, those reporting a need for more education were concentrated in the $6,000-8,999 group and the $3,001-5,999 category. More Anglos than Mexican-Americans, and more rural than urban residents said they needed more health education.

Consideration of informational materials and educational programs should take into account the desired level of content sophistication. It is apparent that content must be digestible and understood by those with a high school education or less and a lower-middle, and upper-lower class income. However, a second category of better educated, middle income families expressed a similar need for more education. This situation could logically use a dual program approach conceived for and tailored to the target groups. Alternative topics have been discussed.

IV A

RECOMMENDATION OF PROPOSAL TOPICS TO MEET SERVICES, FACILITIES, PERSONNEL, AND HEALTH EDUCATION/TRAINING NEEDS

In the future, an arrangement between the New Mexico Regional Medical Program and New Mexico State University could be initiated for the joint development of cooperative proposals concerning tenable solutions to determined needs. Proposals would concern development of programs to meet those needs determined to be high priority.

A discussion of proposal topics for better health care includes four key elements. They are: more and better health manpower, more and better health care facilities, better financing arrangements for the health care of the population, and better planning for health manpower and health care delivery.[72] Improving health care is a complex task of considerable magnitude. To this end, an interdisciplinary approach is required involving such numerous academic fields as medicine, social science, education, economics, business, political science, history, mathematics, computer science, and others. Recommended topics for proposal development pertain to the Southwestern consortium as a unit but can be individualized and adapted to sub-areas as desired.

It is noted that proposals for educational programs in the Southwest consortium involve two different types of education: education for health professionals and education for the general public. With regard to each group the common educational elements of purpose, substance, method, and evaluation need to be adapted to the audience group. Advancements in technology enable selection of educational means from among a wide range of alternatives adaptable to local needs.

NEEDED PERSONNEL AND MANPOWER TRAINING

1. In the Southwest consortium, a reported shortage was frequently mentioned for the general category of physician, and certain physician specialties such as pediatrician and ophthalmologist. One dimension of this problem involves the attraction of practicing physicians to smaller towns and isolated rural areas. Investigation of establishing a system for the use of University of New Mexico Medical School "subinterns" is recommended. This category of personnel, as explained in "Porvenir," represents an untapped source of manpower among medical students who have completed the classic thirty-six months of medical education.[19] Rural service could be an elective or mandatory phase of their medical career.

2. Consideration should be given to creating a permanent office of and position of community consumer and professional health liaison/program development specialist for the Southwest quadrant. The exact job description and function of this position would evolve according to

need and with time. One responsibility of the liaison specialist would involve opening the channels of communication between health care consumer and provider segments (client-physician, client-nurse, client-hospital, etc.). Identification of problems (hospital emergency room conditions, quality and overcrowding of dentist and physician offices, etc.) and mutual needs could be channeled informally and formally through use of this office as a clearinghouse. Information would be analyzed by a specialist and incorporated in specific communications prepared for and distributed to individuals, educational institutions, health care facilities, professional organizations, local and state governments, and legislative bodies. Creation, sponsorship, and funding of such an office and position should be a cooperative venture of government, private, and community interests to provide for balance of perspective and insure integrity.

3. Increased emphasis upon social and behavioral science information and training as integrated into medical, nursing, paraprofessional, and other health personnel education/training curriculums.

NEEDED HEALTH SERVICES

4. Diagnostic and preventative health service needs involving pregnancy, prenatal, and child care involve both the provision of additional manpower (pediatricians, nurses, midwives, etc.) and improved education. Consumer awareness and knowledge of conditions such as edema of pregnancy assist in the informed determination of need for professional health services and their useful allocation of time. It is recommended that investigation be made of a joint venture involving the University of New Mexico Medical Center (providing its medical expertise) and the New Mexico State University Cooperative Extension Service (applying its educational skills and manpower) for the purpose of providing an educational health information program. The pilot model for such a program is an agreement entered into by Auburn University and the University of Alabama as recorded in "The Auburn Alumnews", January, 1973.

Such an educational program need not be confined to one subject area. However, the value and use of diagnostic and preventative services has been identified as a general subject area of need in the Southwest consortium.

5. In order to further meet the needs of diagnostic and preventative health care, it is suggested that proposal be made for the organization and provision of service type paraprofessional services. Specifically senior level explorer scouts, Boy Scouts of America, could be thoroughly and intensively trained in order to qualify as participants in a mass public preventative innoculation program. Such training and participation could be integrated into the scouting curriculum as partial preparation and qualification for required or merit health care training.

6. With regard to general health education, and preferred topics indicated as important by Southwestern consortium sample respondents (general household health level, emergency first aid), it is proposed

that use of a telephone information service be investigated. Specifically, the Southwest quadrant might serve as the pilot model for New Mexico in use of "Tel-Med." The latter is a brand name for a system providing free taped information concerning medical and related problems. Tapes generally run three-five minutes and involve such topics as sex education, "The Rhythm Method." The system can be used to "help people remain healthy by giving them preventative health information, helping them recognize early signs of illness, and helping them adjust to serious illness (Albuquerque Journal, Friday, May 11, 1973).

Use of "Tel-Med" tapes, including Spanish translations, were used in a six-week trial in El Cajon, San Diego County, California. Dr. W. T. Adams, President of the San Diego County Medical Society, said such tapes can help doctors save time by: "recognizing early signs of illness, even cancer; indicate which persons should consult their doctor; help persons adjust to illness or handicaps; and aid in home care for patients." "Tel-Med" is a product of the National Interstate Corporation, Riverside, California.

Use of such a telephone system in the Southwest quadrant would be facilitated by those areas serviced by Mountain States Telephone Company. A company spokesman informed the writer that an arrangement between the company and the government involves a monthly welfare allotment for phone service among low income families. Health survey information indicated low income households as among important target groups for health education.

7. Consideration for initiation of a public education and opinion program urging additional effort, cooperation, and coordination between government agencies and private insurors for discovery of practical means of health care financing for the general public. Moreover a supplementary recommendation involves the investigation of management computer science techniques adapted to health-medical care for the purpose of evaluating the quality of various services delivered. This consideration would focus on optimal levels for health services scheduling, allocation and use of resources, and return on investment through analysis of service quality provided.

FACILITIES NEEDS

8. Further investigation and identification of quadrant area resources is needed for potential use in health education and manpower training. For example, the newly approved Continuing Education branch of New Mexico State University, servicing a segment of the Southwest consortium including Anthony, New Mexico-Texas, might eventually serve as a consortium resource. Potential applications include training of personnel such as dental technicians, and continuing education for upgrading allied health personnel. These possibilities represent potential applications contingent upon demonstrated need, funding, and other work arrangement considerations.

APPENDICES

SECTION A

SELECTED METHODOLOGICAL NOTES

SAMPLING

Selection of the sampling technique involved consideration of the sampling objectives and practical limitations. Representativeness of respondents and independence in their selection were desirable as an approximation of the ideal, a simple random sample with replacement. However, this consideration and sample adequacy were constrained by the practical factors of time, budget, personnel, and an available exhaustive listing of the population in the eight county consortium.* Several alternative sources listing residents for the purpose of drawing a random sample (telephone directories, United States Agricultural Stabilization Conservation Service, county assessors, county clerk and recorder) presented limitations of one type or kind. No one source was discovered with a complete listing of the target population.

The target population for sampling was the general public in the eight southwest New Mexico counties of the consortium.** Only the resident population was considered. The resident population included health professionals since they are consumers of health services. The sampling unit was the household.

A total sample size of 400 seemed desirable in terms of time, budget, and generalizability for the primarily descriptive analysis. The proportion of the consortium total, rural, and urban population, represented by each county was determined.*** The desired sample of 400 was calculated on the percentage basis of 45% from urban areas and 55% from rural areas. This modification of a true proportional sample was made because of the need to adequately provide for representa-

*A determination was made by the Southwest CHESS steering committee, including Ms. Flood, Texas Regional Medical Program representative in El Paso, to include El Paso, Texas at some future time. The plans of the Texas Regional Medical Program in El Paso were recognized and the means for future coordination established. In April, 1973, the writer met with Ms. Flood and invited her to include any information from the El Paso area in the Southwest CHESS report. The offer was extended in various follow-up telephone calls.

**It is noted that New Mexico State health planning area number 5 includes all Southwest consortium counties except Otero.

***It is assumed that the 1971 Agricultural Experiment Station Report data is a reliable estimate of the population.

tion of the rural segment, an important component of the health care situation in New Mexico. The latter are numerically underrepresented in the state's population. It was thought that limitations resulting from this modification of a truly proportional sample would be slight compared to the benefits gained in ensuring representation of rural households.[48]

Samples for both rural and urban areas were drawn through the use of random sets of coordinates applied to county section maps and urban tract and block maps. In rural areas many sections contained only one residence whose location was variously distributed according to directional location within the sample. In the case of sections containing more than one residence, a random selection was made. Only one residence was interviewed in each section.

Within urban areas it is recognized that city blocks are sometimes homogeneous with regard to certain household characteristics. However, only one household was interviewed from each randomly selected block. A table of random numbers was used to designate the number of the target household in each block. Only one residence from each block was interviewed.

Interviewers were obligated to make one call back so as to minimize possible bias between respondents interviewed and non-respondents apparently not at home. A standard substitution rule applied to both rural and urban households.

As mentioned, each means of selecting a simple random sample presented some practical limitation. It is recognized that the sampling is a modification of the random method. After discussion with statisticians it was thought that the method used did not preclude the requirement of independence of observations for the chi-square test.[4] However, the sample is slightly biased in the direction of rural households. Those using the data should be aware of its limitations and compensate accordingly.

It is not concluded that the sample is a true representation of the Southwest consortium. Nevertheless it is thought that the modifications in view of existing circumstances were advisable and in the interest of the survey. It is thought that these modifications resulted in errors that are insignificant and will not greatly affect the survey results. Considering limitations, the sample is a useful approximation of the population.

LIMITATIONS OF SURVEY RESULTS

Interpretation and results of the Southwest quadrant survey are limited to the geographical area of the consortium and should not be generalized to other quadrants in the state.

The extent to which the sample of respondents is representative of the total population of residents in the Southwestern consortium has not been fully determined.

The possible impact of tourists and visitors on the health care needs of the quadrant were not considered.

Reliability of results needs to be established through readministration of the same personal interview guide.

It is assumed that personal interview guide questions measured what they were intended to measure on one dimension (face validity).

SECTION B

EXHIBIT 1

COUNTY RESIDENCE LOCATION

Total Survey Respondents 400

County	Frequency	% of Total Responses
Total no. respondents	400	100%
Dona Ana	157	39
Otero	100	25
Grant	50	13
Luna	28	7
Socorro	24	6
Sierra	17	4
Catron	12	3
Hidalgo	12	3
TOTAL RESPONSES	400	100%

EXHIBIT 2

NEAREST POPULATION HEALTH CENTER SERVICES

Nearest Population Health Center Location	Frequency	% of Total Population Center Response
Total no. respondents	400	100%
Las Cruces	160	40
Alamogordo	90	23
Silver City	51	13
Deming	33	8
Socorro	29	7
Truth or Consequences	19	5
Lordsburg	11	3
Mescalero	5	1
Carrizozo	1	0
Ruidoso	1	0
White Sands	0	0
TOTAL NEAREST POPULATION CENTER RESPONSES	400	100%

EXHIBIT 3

APPROXIMATE DISTANCE TO NEAREST
ACCESSIBLE POPULATION HEALTH
CENTER/SERVICES

Total Survey Respondents 400

Distance by Mileage Category	Frequency	% of Total Responses
Total no. respondents	400	100%
Resident	112	28
Within 5 miles	20	5
6-10 miles	22	6
11-20 miles	55	14
21-30 miles	40	10
31-40 miles	35	9
41-50 miles	31	8
over 50 miles	85	21
TOTAL RESPONSES	400	100%

EXHIBIT 4

URBAN OR RURAL RESIDENCE LOCATION

Total Survey Respondents 400

	Frequency	% of Combined Total Responses
Total Rural Response	220	55%
Total Urban Response	180	45%
COMBINED TOTAL RESPONSES	400	100%

Urban Residence Location	Frequency	% of Urban Responses
Total no. respondents	180	100%
Las Cruces	58	32
Alamogordo	42	24
Silver City	24	13
Population centers of more than 75 people but not listed in 1-11	15	8
Deming	13	7
Socorro	8	5
Truth or Consequences	9	5
Lordsburg	6	3
Mescalero	5	3
Carrizozo	0	0
Ruidoso	0	0
White Sands	0	0
TOTAL RESPONSES	180	100%

EXHIBIT 4a

URBAN OR RURAL RESIDENCE LOCATION
(CONTINUED)

Rural Residence Location	Frequency	% of Rural Responses
Total no. respondents	220	100%
Open rural, farms, ranches	167	76
Less than 75 people in a small village or cluster of residences separated by an equivalent distance of not more than six average city blocks	53	24
TOTAL RESPONSES	220	100%

HEALTH CARE LOCATION MOST FREQUENTLY USED BY HOUSEHOLD

Total Survey Respondents 400

	Frequency	% of Combined Total Responses
Nearby Population Center	265	66
Other Health Center	129	32
No Response	6	2
COMBINED TOTAL RESPONSES	400	100%

Nearby Population Health Center Location	Frequency	% of Total Population Center Responses
Total no. respondents	265	100
Las Cruces	95	36
Alamogordo	55	21
Silver City	46	17
Deming	27	10
Socorro	14	5
Truth or Consequences	9	4
Lordsburg	7	3
Mescalero	6	2
Ruidoso	3	1
White Sands	3	1
Carrizozo	0	0
TOTAL NEARBY POPULATION CENTER RESPONSES	265	100%

EXHIBIT 5a

HEALTH CARE LOCATION MOST FREQUENTLY
USED BY HOUSEHOLD (CONTINUED)

Other Health Center Location	Frequency	% of Total Other Health Center Responses
Total no. respondents	129	100
Other	54	42
El Paso	52	40
Albuquerque	14	11
Belen	4	3
Tucson	4	3
Safford/Springerville	1	1
Phoenix	0	0
TOTAL RESPONSES MAJOR HEALTH CENTER, OTHER	129	100%

EXHIBIT 6

CURRENT FINANCIAL HEALTH PROTECTION FOR HEAD OF HOUSEHOLD

Total Survey Respondents 400

Type of Coverage	Frequency	% of Total Responses
Total no. respondents	389	100%
Group insurance (work)	155	30
Private insurance	147	28
Personal economic resources	101	19
Medicare/Medicaid	65	13
No	38	7
Guaranteed financial assistance from relatives or friends	5	1
Employees disability insurance	4	1
Don't Know	7	1
Religious/brotherhood support	1	0
TOTAL RESPONSES*	523	100%
Frequency of Multiple Responses	112	29

*Total number of responses exceeds total number of respondents due to multiple responses.

EXHIBIT 7

GENERAL HOUSEHOLD HEALTH LEVEL

Total Survey Respondents 400

Household Health Level	Frequency	% of Total Responses
Total no. respondents	399	100
Excellent, rare sickness	152	38
Good, some sickness but infrequent	170	43
Fair, some sickness alternating with good health	53	13
Poor, continuous or frequent sickness of some type	24	6
TOTAL RESPONSES	399	100%

EXHIBIT 8

MEMBERS OF HOUSEHOLD WITH SPECIAL/RECURRENT HEALTH PROBLEMS

Total Survey Respondents 400

Recurrent Health Problem	Frequency	% of Total Responses
No	279	70
Yes	120	30
No Response	1	0
TOTAL RESPONSES	400	100%

EXHIBIT 9

NAME OF SPECIAL/RECURRENT
HEALTH PROBLEMS IF 'YES'
(Continued on Following Page)

Total Survey Respondents 400

Name of Recurrent Problem	Frequency	% of Total Responses
Total no. respondents	120	100%
Arthritis	20	17
Diabetes	14	12
Heart trouble	12	10
Hay fever, sinus, allergies	12	10
Asthma	9	8
Glaucoma/cataracts	5	4
Cancer	5	4
Hypertension	5	4
Physically handicapped, limps	5	4
Poor blood circulation	3	3
Anemia	3	3
Blood disorder	4	3
Ulcer/stomach problem	3	3
Colon trouble	2	2
Rheumatism/gout	2	2
Migraine headaches	2	2
Liver trouble	2	2
Alcoholism	2	2
Multiple Sclerosis, paralysis	1	1

EXHIBIT 9a

NAME OF SPECIAL/RECURRENT HEALTH PROBLEMS IF 'YES' (continued)

Emphysema	1	1
Epilepsy	1	1
Bronchitis	1	1
Bone deterioration	1	1
Bladder trouble	1	1
Nervousness	1	1
Kidney trouble, renal impairment	1	1
Back trouble	1	1
Infirmities, complications of old age	1	1
TOTAL RESPONSES	120	100%

EXHIBIT 10

EXISTING HOUSEHOLD NEEDS TO FACILITATE CARE OF SPECIAL/RECURRENT HEALTH PROBLEMS

Total Survey Respondents 400

What Needs To Be Provided	Frequency	% of Total Responses
Total no. respondents	15	100%
Need health care personnel closer to household (nonspecific)	4	27
Need examination by specialist, need specialist close by	3	20
Physical equipment (air conditioner, mechanical breathing device)	3	20
Medication more readily available	1	7
Religious help, miracle from God	1	7
Additional economic assistance private insurance	1	7
Surgery	1	7
Better quality medical attention, good doctors take care of my problems	1	7
TOTAL RESPONSES	15	100%

EXHIBIT 11

EXISTING NEEDS FOR REHABILITATION OF HOUSEHOLD MEMBERS WITH SPECIAL/RECURRENT HEALTH PROBLEMS

Total Survey Respondents 400

What Needs to be Provided?	Frequency	% of Total Responses
Total no. respondents	15	100%
Need better professional care, additional specialist	4	25
Need high power glasses	3	20
Physical therapy	3	20
Need someone close by--- depend on	1	7
More medication	1	7
Follow special diet	1	7
Curtail exercise, activity	1	7
Financial support--government	1	7
TOTAL RESPONSES	15	100%

EXHIBIT 12

MOST IMPORTANT SYMPTOMS
USED IN DETERMINING ILLNESS

Total Survey Respondents 400

Symptoms	Frequency	% of Total Responses
Total no. respondents	395	
Body temperature, fever, chills	300	26
Aches, pains	198	17
Change in behavioral habits (tired, sex, appetite, weak, eating, sleeping, shaky)	193	16
Respiratory, nasal congestion, difficulty breathing, cough, runny nose	154	13
Change in attitude, moody, grouchy, sad, nervous feelings	144	12
Nausea, discomfort, vomiting, diarrhea	94	8
Change in appearance, color, skin disorders	72	6
Pulse, dizziness, elevated blood pressure	19	2
Tells me so	2	0
TOTAL RESPONSES*	1176	100%

*Totals include multiple responses

MOST FREQUENT FIRST, SECOND, AND THIRD CHOICE
SYMPTOMS USED IN DETERMINING ILLNESS

Total Survey Respondents 400

	Choice of Symptoms					
	1st Choice		2nd Choice		3rd Choice	
Symptoms	F	%	F	%	F	%
Body temperature, fever, chills	164	42	81	21	55	14
Aches, pains	55	14	77	19	66	17
Change in attitude, moody, grouchy, sad, nervous feelings	45	12	46	12	53	14
Respiratory, nasal congestion, difficulty breathing, cough, runny nose	47	12	63	16	44	11
Change in behavioral habits (tired, sex, appetite, weak, eating, sleeping, shaky)	41	10	61	15	91	24
Nausea, discomfort, vomiting, diarrhea	20	5	31	8	43	11
Change in appearance, color, skin disorders	17	4	31	8	24	6
Change in pulse rate, dizziness, elevated blood pressure	5	1	4	1	10	3
Tells me so	1	0	0	0	1	0
TOTAL RESPONSES	395	100%	394	100%	387	100%

Important Sources Of Influence In The Illness Process

TOTAL SURVEY RESPONDENTS 400

EXHIBIT 13

Sources Of Influence

Stages of the Illness Process	Myself		Physician (GP or Specialist)		Chiropractor		Nurse		Friends		Relatives		Pharmacist, Druggist		Self Treatment		Other	
	F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
Determination of Illness	126	32	235	59	-	-	-	-	2	7	32	8	1	0	1	0	2	1
COMBINED TOTAL RESPONSES	399																	
Discussing Illness and Possible Causes	28	7	245	61	-	-	-	-	9	2	83	12	1	0	-	-	34	9
COMBINED TOTAL RESPONSES	400																	
Who Do You See First For Diagnosis	18	4	316	81	2	1	2	0	6	2	53	13	1	0	1	0	1	0
COMBINED TOTAL RESPONSES	382																	
Accepting Fact Of Illness	27	7	318	80	2	1	-	-	2	1	48	12	1	0	-	-	2	1
COMBINED TOTAL RESPONSES	400																	
Who Do You See First For Treatment	4	1	379	92	2	1	-	-	3	1	8	3	2	1	-	-	2	1
COMBINED TOTAL RESPONSES	400																	
Following Prescribed Treatment	10	1	351	88	1	0	1	0	4	1	25	6	3	1	1	0	4	1
COMBINED TOTAL RESPONSES	400																	
Discontinuance Of Activities	117	29	238	60	1	0	-	-	1	0	39	10	1	0	1	0	2	1
COMBINED TOTAL RESPONSES																		
Deciding Recovery	202	51	166	42	1	0	-	-	-	-	31	8	-	-	-	-	-	-
COMBINED TOTAL RESPONSES	400																	

EXHIBIT 14

HOUSEHOLD MEMBERS WHO USED
HEALTH MANPOWER FOR SERVICES IN THE LAST FIVE YEARS

Total Survey Respondents 400

Health Manpower	Evaluation: Excellent F	Excellent %	Good F	Good %	Fair F	Fair %	Poor F	Poor %	Don't Know F	Don't Know %	Total # Respondents Using
Total no. responses*	1325		144		71		35		26		
M.D. Family Doctor (G.P.)	241	69	57	16	30	9	12	3	7	2	347
M.D. Specialist	164	89	11	6	6	3	3	2	--	--	184
Osteopath	36	67	4	7	6	11	5	9	3	6	54
Chiropractor	59	63	12	13	8	9	7	8	7	8	93
Naturopath	3	75	1	25	--	--	--	--	--	--	4
Midwife	2	67	1	33	--	--	--	--	--	--	3
Astrologer	1	100	--	--	--	--	--	--	--	--	1
Faith healer (Christian Science Practitioner)	3	100	--	--	--	--	--	--	--	--	3
Yerbero	1	100	--	--	--	--	--	--	--	--	1
Curandero	2	40	1	20	2	40	--	--	--	--	5
Dentist	225	82	30	11	11	4	3	1	5	2	274
Optometrist	185	91	10	5	4	2	2	1	3	1	204
Opthalmologist (M.D. eye doctor)	105	97	1	1	1	1	1	1	--	--	108
Druggist (Pharmacist)	206	93	14	6	2	1	--	--	--	--	222
Nurse (including school and public health)	81	96	1	1	--	--	2	2	--	--	84
Physicians assistant/ paraprofessional	10	77	1	8	1	8	--	--	1	8	13
Black Magic	1	100	--	--	--	--	--	--	--	--	1

*Totals include responses to multiple items.

EXHIBIT 14a

HOUSEHOLD MEMBERS WHO DID NOT USE HEALTH MANPOWER FOR SERVICES IN THE LAST FIVE YEARS

Total Survey Respondents 400

Health Manpower	Totals Did you need to use				Totals Did you know about			
	Yes		No		Yes		No	
	F	%	F	%	F	%	F	%
Total no. responses*	83		5110		1905		3236	
M.D. Family Doctor (G.P.)	7	13	46	87	46	87	7	13
M.D. Specialist	7	3	207	97	171	80	43	20
Osteopath	2	1	345	99	213	61	134	39
Chiropractor	4	1	301	99	185	61	119	39
Naturopath	0	0	396	100	113	29	282	71
Midwife	2	1	396	99	84	21	312	79
Astrologer	0	0	399	100	41	10	357	90
Faith healer (Christian Science Practitioner)	1	0	396	100	57	14	339	86
Yerbero	3	1	396	99	50	13	349	87
Curandero	3	1	395	99	62	16	336	84
Dentist	13	11	110	89	92	75	31	25
Optometrist	20	10	173	90	161	83	32	17
Opthalmologist (M.D. eye doctor)	20	7	271	93	219	75	72	25
Druggist (Pharmacist)	0	0	178	100	109	61	69	39
Nurse (including school and public health)	1	0	315	100	194	61	122	39
Physicians assistant/ paraprofessional	0	0	387	100	118	30	269	70
Black magic	0	0	399	100	36	9	363	91

*Totals include responses to multiple items.

EXHIBIT 15

HOUSEHOLD MEMBERS WHO USED
HEALTH SERVICE FACILITIES IN THE LAST FIVE YEARS

Total Survey Respondents 400

Facilities	Evaluation: Excellent F	Excellent %	Good F	Good %	Fair F	Fair %	Poor F	Poor %	Don't Know F	Don't Know %	Total # Respondents Using
Total no. responses*	1099		90		59		48		8		
City, County, Community hospital	131	68	29	15	15	8	16	8	2	1	193
Private and/or religious hospital	41	91	2	4	2	4	--	--	--	--	45
Bureau of Indian Affairs or United States Public Health Service Clinic	10	83	--	--	--	--	1	8	1	8	12
Neighborhood or population center health clinic	26	74	6	17	2	6	1	3	--	--	35
Nursing home, home for the aged	2	40	1	20	1	20	1	20	--	--	5
Sanatorium	1	100	--	--	--	--	--	--	--	--	1
Mobile unit (diagnostic and/or treatment)	9	100	--	--	--	--	--	--	--	--	9
Ambulance	39	95	1	2	1	2	--	--	--	--	41
School nurses office or clinic	72	99	1	1	--	--	--	--	--	--	73
Military hospital/ facilities or Veteran's Administration facilities	42	88	--	--	3	6	3	6	--	--	48
Drugstore	257	93	15	5	3	1	1	0	--	--	276
Our home	205	99	--	--	--	--	2	1	--	--	207
Physician, dentist, etc. office	176	77	27	12	19	8	4	2	2	1	228
Hospital emergency room	88	67	8	6	13	10	19	15	3	2	131
Special migrant worker facilities											

*Totals include responses to multiple items.

EXHIBIT 15a

HOUSEHOLD MEMBERS WHO DID NOT USE HEALTH SERVICE FACILITIES IN THE LAST FIVE YEARS

Total Survey Respondents 400

Facilities	Totals Did You Need To Use				Totals Did You Know About			
	Yes		No		Yes		No	
	F	%	F	%	F	%	F	%
Total no. responses*	25		4664		2429		2257	
City, County, Community hospital	3	1	204	99	190	91	18	9
Private and/or religious hospital	0	0	355	100	233	66	122	34
Bureau of Indian Affairs or United States Public Health Service Clinic	0	0	388	100	158	41	230	59
Neighborhood or population center health clinic	3	1	363	99	193	53	172	47
Nursing home, home for the aged	3	1	392	99	190	48	205	52
Sanatorium	1	0	398	100	105	26	294	74
Mobile unit (diagnostic and/or treatment)	0	0	391	100	116	30	275	70
Ambulance	9	3	348	97	300	84	58	16
School nurses office or clinic	1	0	327	100	194	59	133	41
Military hospital/ facilities or Veteran's Administration facilities	1	0	352	100	224	64	127	36
Drugstore	0	0	122	100	62	50	62	50
Our home	1	1	189	99	76	40	116	60
Physician, dentist, etc. office	1	1	172	99	91	53	81	47
Hospital emergency room	2	1	266	99	222	83	44	17
Special migrant worker facilities	0	0	397	100	75	19	320	81

*Totals include responses to multiple items.

EXHIBIT 16

HOUSEHOLD MEMBERS WITH CONDITIONS WHO USED
HEALTH SERVICES/FACILITIES IN THE LAST FIVE YEARS

Total Survey Respondents 400

Condition/Service	Evaluation														Total # Responses Using
	Excellent		Good		Fair		Poor		Don't Know						
	F	%	F	%	F	%	F	%	F	%					
Total no. of Responses*	1256		89		47		32		18						
Accidents/broken bones	95	80	6	5	6	5	10	8	2	2					119
Burns	21	84	3	12	1	4	--	--	--	--					25
Infectious diseases (measles, mumps)	40	93	1	2	1	2	1	2	--	--					43
Minor surgery (cyst and wart removal)	75	85	7	8	2	2	3	3	1	1					88
Major surgery (hysterectomy)	80	85	5	5	3	3	6	6	0	0					94
Respiratory (T.B., emphysema, pneumonia)	43	90	3	6	2	4	--	--	--	--					48
Cancer and terminal illness	9	75	1	8	--	--	--	--	2	17					12
Out-patient laboratory work (blood sample, urinalysis)	189	91	9	4	4	2	3	1	3	1					208
Family Planning Services (Birth control)	25	96	1	4	--	--	--	--	--	--					26
Chiropractic adjustments	60	78	6	8	2	3	3	4	6	8					77
Mental/emotional/drugs/ alcohol	7	88	1	13	--	--	--	--	--	--					8
Toothache/tooth repair	175	85	22	11	9	4	--	--	--	--					206
False teeth	95	91	4	4	2	2	1	1	2	2					104
Colds and/or flu virus	168	83	16	8	13	6	3	1	2	1					202
"Susto"	3	50	1	17	1	17	1	17	--	--					6
Glasses, contact lenses	151	97	3	2	1	1	1	1	--	--					156
Eye surgery, cataracts	20	100	--	--	--	--	--	--	--	--					20

*Totals include responses to multiple items.

EXHIBIT 16a

HOUSEHOLD MEMBERS WHO DID NOT USE HEALTH SERVICES/FACILITIES IN THE LAST FIVE YEARS REGARDLESS OF CONDITION

Total Survey Respondents 400

Condition/Service	Totals Did You Need To Use Service For: Yes F	Yes %	NO F	NO %	Totals Did You Know About Service: Yes F	Yes %	No F	No %
Total no. of Responses*	118		5230		4137		1194	
Accidents/broken bones	0	0	281	100	261	93	20	7
Burns	2	1	373	99	343	92	31	8
Infectious diseases (measles, mumps)	2	1	355	99	311	87	45	13
Minor surgery (cyst and wart removal)	6	2	305	98	276	89	33	11
Major surgery (hysterectomy)	4	1	301	99	267	88	37	12
Respiratory (T.B., emphysema, pneumonia)	1	0	351	100	320	91	32	9
Cancer and terminal illness	0	0	387	100	346	90	40	10
Out-patient laboratory work (blood sample, urinalysis)	2	1	190	99	157	82	34	18
Family Planning Services (Birth control)	10	3	364	97	228	61	146	39
Chiropractic adjustments	1	0	322	100	190	59	132	41
Mental/emotional/drugs/ alcohol	9	2	383	98	210	54	181	46
Toothache/tooth repair	13	7	180	93	144	75	47	25
False teeth	13	4	283	96	245	84	48	16
Colds and/or flu virus	20	10	178	90	160	81	37	19
"Susto"	1	0	391	100	195	50	194	50
Glasses, contact lenses	24	10	217	90	183	76	59	24
Eye surgery, cataracts	10	3	369	97	301	79	78	21

*Totals include responses to multiple items.

EXHIBIT 17

HOUSEHOLD MEMBERS WHO USED DIAGNOSTIC/PREVENTATIVE SERVICES IN THE LAST FIVE YEARS

Total Survey Respondents 400

Services	Evaluation										Total # Respondents Using
	Excellent		Good		Fair		Poor		Don't Know		
	F	%	F	%	F	%	F	%	F	%	
Total no. Responses*	624		7		3		1		2		
Vaccination, innoculation	152	99	--	--	1	1	--	--	--	--	153
Sex education and venereal disease prevention	28	100	--	--	--	--	--	--	--	--	28
Nutrition and foods	18	95	--	--	1	5	--	--	--	--	19
Diagnostic (T.B. X-ray, T.B. patch, pap smear, diabetic urinalysis detection)	232	97	4	2	--	--	1	0	1	0	238
Annual or regular physical examination	194	97	3	2	1	1	--	--	1	1	199

*Totals include responses to multiple items.

EXHIBIT 17a

HOUSEHOLD MEMBERS WHO DID NOT USE DIAGNOSTIC/PREVENTATIVE SERVICES IN THE LAST FIVE YEARS

Total Survey Respondents 400

Services	Did You Need To Use				Did You Know About			
	Yes		No		Yes		No	
	F	%	F	%	F	%	F	%
Total no. responses*	67		1292		885		448	
Vaccination, innoculation			246	100	201	81	46	19
Sex education and venereal disease prevention	3	1	369	99	202	54	146	46
Nutrition and foods	3	1	378	99	197	52	182	48
Diagnostic (T.B. X-ray, T.B. patch, pap smear, diabetic urinalysis detection)	5	3	156	97	125	78	35	22
Annual or regular physical examination	56	28	143	72	160	80	39	20

*Totals include responses to multiple items.

EXHIBIT 18

HOUSEHOLD MEMBERS WHO USED PREGNANCY, PRENATAL, AND/OR POSTNATAL SERVICES IN THE LAST FIVE YEARS

Total Survey Respondents 400

Services	Evaluation: Excellent F	Excellent %	Good F	Good %	Fair F	Fair %	Poor F	Poor %	Don't know F	Don't know %	Total # Respondents Using
Total no. Responses*	184		7		2		2		0		
Prenatal services	69	93	3	4	--	--	2	3	--	--	74
Delivery	66	96	2	3	1	1	--	--	--	--	69
Postnatal, pediatric, and child health care	49	94	2	4	1	2	--	--	--	--	52

*Totals include responses to multiple items.

EXHIBIT 18a

HOUSEHOLD MEMBERS WHO DID NOT USE PREGNANCY, PRENATAL, AND/OR POSTNATAL SERVICES IN THE LAST FIVE YEARS

Total Survey Respondents 400

Services	Did You Need To Use				Did You Know About			
	Yes		No		Yes		No	
	F	%	F	%	F	%	F	%
Total no. Responses*	15		989		563		440	
Prenatal services	3	1	323	99	180	55	146	45
Delivery	2	1	329	99	185	56	146	44
Postnatal, pediatric, and child health care	10	3	337	97	198	57	148	43

*Totals include responses to multiple items.

EXHIBIT 19

HOUSEHOLD SATISFACTION WITH HEALTH SERVICES/CARE RECEIVED

Total Survey Respondents 400

Satisfaction	Frequency	% of Total Responses
Total no. responses	398	
Very Satisfied	281	70
Partially Satisfied	92	23
Partially Dissatisfied	9	2
Very Dissatisfied	16	4
TOTAL RESPONSES	398	100%

EXHIBIT 20

PREFERRED MEANS OF LEARNING MORE ABOUT
HEALTH/MEDICAL CARE EDUCATION

Total Survey Respondents 400

Means of Learning	Frequency	% of Total Responses
Total no. respondents	398	
Television and radio	207	20
Adult education courses	185	18
Newspapers and Magazines	135	13
Special literature and pamphlets	136	13
Talks with friends or relatives	96	9
Educational movies	85	8
Contact at home by voluntary or public health organization workers	81	8
Lectures and discussions with people	58	6
Mobile educational van	36	4
Other (specify)	7	1
TOTAL RESPONSES*	1026	100%

*Totals include multiple responses

EXHIBIT 21

PREFERRED TOPICS FOR
HEALTH/MEDICAL CARE LEARNING/TRAINING
(Continued on Following Page)

Total Survey Respondents 400

Preferred Topics	Frequency	% of Total Responses
Total no. respondents	398	
General household health care	287	16
Emergency first aid	261	15
Homemaker, home nursing skills	153	9
Health care for elderly people	136	8
Dental hygiene	114	7
Follow-up care after illness	103	6
Nutrition (meal planning, diets)	96	6
Infant and child care	82	5
Disaster training (floods, fires, tornados, etc.)	88	5
Family planning (birth control)	66	4
Sanitation household practices (garbage, waste disposal)	61	4
Animal control and health	53	3
Insect control	60	3

EXHIBIT 21a

PREFERRED TOPICS FOR
HEALTH/MEDICAL CARE LEARNING/TRAINING
(Continued)

Services for the handicapped (including speech and hearing impairments)	55	3
Prenatal care	43	2
Understanding and rehabilitation for military veterans	38	2
Health problems for migrant workers	37	2
Other	7	0
TOTAL RESPONSES*	1740	100%

*Totals include multiple responses

EXHIBIT 22

HOUSEHOLD NEED FOR MORE
HEALTH EDUCATION/TRAINING

Total Survey Respondents 400

Need For More	Frequency	% of Total Responses
Yes	235	59
No	165	41
TOTAL RESPONSES	400	100%

EXHIBIT 23

WAS RESPONDENT HEAD OF HOUSEHOLD

Total Respondents 400

Head of Household	Frequency	% of Total Responses
Yes	191	48
No	209	52
TOTAL RESPONSES	400	100%

EXHIBIT 24

AGE OF HEAD OF HOUSEHOLD

Total Survey Respondents 400

Age	Frequency	% of Total Responses
Total no. Responses	392	100%
20-29	12	3
30-39	71	18
40-49	107	27
50-59	92	24
60-69	55	14
70-79	43	11
80-89	12	3
TOTAL RESPONSES	392	100%
MEAN AGE	48	

EXHIBIT 25

AGE OF RESPONDENTS WHO WERE
NOT THE HEAD OF HOUSEHOLD

Total Survey Respondents 400

Age	Frequency	% of Total Responses
Total no. responses	207	100%
25-30	46	22
31-40	52	25
41-50	55	27
51-60	39	19
61-70	8	4
71-83	7	3
TOTAL RESPONSES	207	100%
MEAN AGE	41	

EXHIBIT 26

RESPONDENTS RELATION TO
HEAD OF HOUSEHOLD

Total Survey Respondents 400

Relation	Frequency	% of Total Responses
Total no. respondents	399	100%
Same	191	47
Spouse	182	45
Daughter	11	3
Other relative	6	2
Other	7	2
Son	3	1
TOTAL RESPONSES	400	100%

EXHIBIT 27

RESPONDENTS SEX

Total Survey Respondents 400

Sex	Frequency	% of Total Responses
Total no. respondents	398	100%
Female	243	61
Male	157	39
TOTAL RESPONSES	400	100%

EXHIBIT 28

DURATION OF RESIDENCE
(Continued on Following Page)

Total Survey Respondents 400

Time Period	Frequency	% of Total Responses
STATE		
Years		
1-10	92	24
11-20	44	12
21-30	66	18
31-40	44	12
41-50	58	15
51-60	51	13
61-70	21	6
TOTAL RESPONSES	376	100%
COUNTY		
Years		
1-10	124	33
11-20	57	15
21-30	63	16
31-40	45	12
41-50	42	11
51-60	38	10
61-70	10	3
TOTAL RESPONSES	379	100%

EXHIBIT 28a

DURATION OF RESIDENCE
(CONTINUED)

Total Survey Respondents 400

CURRENT ADDRESS

Years	Frequency	% of Total Responses
1-10	223	57
11-20	78	20
21-30	42	10
31-40	23	6
41-50	15	4
51-60	11	3
61-70	1	0
TOTAL RESPONSES	393	100%

EXHIBIT 29

NUMBER OF PEOPLE LIVING IN HOUSEHOLD

Total Survey Respondents 400

Number of People	Frequency	% of Total Responses
Total no. responses	394	100%
1	34	9
2	113	29
3	68	17
4	66	17
5	47	12
6	25	6
7	19	5
8	10	3
9	5	1
10	2	1
11	4	1
25	1	0
TOTAL RESPONSES	394	100%

EXHIBIT 30

HOUSEHOLD INCOME BEFORE TAXES

Total Survey Respondents 400

Income	Frequency	% of Total Responses
Total no. Responses	388	100%
Under $1000 year	10	3
$1001 - $3000	66	17
$3001 - $5999	71	18
$6000 - $8999	72	19
$9000 - $12,000	59	15
$12,001 - $15,000	33	9
$15,001 - $20,000	32	8
Over $20,000	45	12
Total Responses	388	100%

EXHIBIT 31

HEAD OF THE HOUSEHOLDS RELIGION

Total Survey Respondents 400

Religion	Frequency	% of Total Responses
Total no. respondents	399	100%
Protestant	189	47
Catholic	157	39
None	41	10
Other	12	3
TOTAL RESPONSES	399	100%

EXHIBIT 32

ETHNIC GROUP OF HOUSEHOLD HEAD

Total Survey Respondents 400

Ethnic Group	Frequency	% of Total Responses
Total no. respondents	399	100%
Anglo	241	60
Spanish-American, Mexican-American, Mexican	140	35
Indian	10	3
Black	4	1
Other	4	1
TOTAL RESPONSES	399	100%

EXHIBIT 33

HIGHEST GRADE IN SCHOOL COMPLETED BY HEAD OF HOUSEHOLD

Total Survey Respondents 400

Grade	Frequency	% of Total Responses
Total no. responses	399	100%
1. Professional	19	5
2. Four Year College Graduate	32	8
3. One-Three Years College	45	11
4. High School Graduate	99	25
5. Ten-Eleven Years School	41	10
6. Seven-Nine Years School	62	16
7. Under Seven Years School	83	21
8. Unknown	18	5
TOTAL RESPONSES	399	100%

EXHIBIT 34

OCCUPATION OF HEAD OF HOUSEHOLD

Total Survey Respondents 400

Occupation	Frequency	% of Total Responses
Total no. respondents	400	100%
Unskilled Employees*	87	23
Skilled Manual Employees	80	20
Retired	71	18
Clerical and Sales Workers, Technicians and Owners of Small Businesses	51	13
Administrative Personnel, Owners of Small Businesses	44	11
Higher Executive of Large Concerns, Major Professionals	30	8
Machine Operators and Semiskilled	30	8
Business Managers, Lesser Professionals, Proprietors of Medium Sized Business	7	2
TOTAL RESPONSES	400	100%

*Includes unemployed according to the social position scale.

EXHIBIT 35

EMPLOYER OF HEAD OF HOUSEHOLD

Total Survey Respondents 400

Employer	Frequency	% of Total Response
Total no. respondents 400	396	100%
Self Employed	114	29
Works for a Private Company	116	29
Retired	71	18
Works for the Government (Federal, State, or Local)	58	15
Other	28	7
Military	9	2
TOTAL RESPONSES	396	100%

SECTION C

EXHIBIT 36

DOES HEAD OF HOUSEHOLD CURRENTLY HAVE A DRIVERS LICENSE

Total Survey Respondents 400

Drivers License	Frequency	% of Total Responses
Total no. responses	399	100%
Yes	362	91
No	37	9
TOTAL RESPONSES	399	100

EXHIBIT 37

DOES HEAD OF HOUSEHOLD
CURRENTLY HAVE AN AUTOMOBILE

Total Survey Respondents 400

Automobile	Frequency	% of Total Responses
Total no. responses	399	100%
Yes	368	92
No	31	8
TOTAL RESPONSES	399	100%

EXHIBIT 38

CLASSIFICATION OF ROADS NEAR HOUSEHOLD

Total Survey Respondents 400

Roads Classification	Frequency	% of Total Responses
Total no. responses	382	100%
All weather Roads Always Accessible within 1/4 Mile	235	62
Secondary Roads Passable Most of the Time	128	34
Seasonal Non-Passable Roads	17	4
Other	2	1
TOTAL RESPONSES	382	100%

EXHIBIT A

Residence County Location By Most Frequently Go For Health/Medical Care
(Continued on Following Page)

TOTAL SURVEY RESPONDENTS 400

Most Frequently Go

Nearest Large Population Center	County Location									
	Dona Ana		Otero		Grant		Luna		Socorro	
	F	%	F	%	F	%	F	%	F	%
TOTAL NO. RESPONDENTS *	156	40	100	25	49	12	28	7	23	6
Alamogordo	0	0	54	54	0	0	1	4	0	0
Carrizozo	0	0	0	0	0	0	0	0	0	0
Deming	2	1	0	0	1	2	23	82	0	0
Las Cruces	94	60	0	0	0	0	0	0	0	0
Lordsburg	0	0	0	0	4	8	0	0	0	0
Mescalero	0	0	6	6	0	0	0	0	0	0
Ruidoso	0	0	3	3	0	0	0	0	0	0
Silver City	3	2	1	1	36	73	0	0	1	4
Socorro	0	0	0	0	0	0	0	0	11	48
Truth or Consequences	0	0	0	0	0	0	0	0	1	4
White Sands	3	2	0	0	0	0	0	0	0	0
Major Health Center										
Albuquerque	1	1	0	0	1	2	0	0	5	22
Belen	0	0	0	0	0	0	0	0	3	13
El Paso	34	22	10	10	0	0	3	11	0	0
Tucson	0	0	0	0	1	2	0	0	0	0
Phoenix	0	0	0	0	0	0	0	0	0	0
Safford/Springerville	0	0	0	0	1	2	0	0	0	0
Other	19	12	26	26	5	10	1	4	2	9
TOTAL RESPONSES		100%		100%		100%		100%		100%

*Total excludes no responses

EXHIBIT A_1

Residence County Location By Most Frequently Go For Health/Medical Care
(Continued)

TOTAL SURVEY RESPONDENTS 400

Most Frequently Go

Nearest Large Population Center	County						
	Sierra		Catron		Hidalgo		Total
	F	%	F	%	F	%	
TOTAL NO. RESPONDENTS	14	4	12	3	12	3	394
Alamogordo	0	0	0	0	0	0	55
Carrizozo	0	0	0	0	0	0	0
Deming	1	7	0	0	0	0	27
Las Cruces	0	0	0	0	1	8	95
Lordsburg	0	0	0	0	3	25	7
Mescalero	0	0	0	0	0	0	6
Ruidoso	0	0	0	0	0	0	3
Silver City	0	0	3	25	2	17	46
Socorro	0	0	3	25	0	0	14
Truth or Consequences	8	57	0	0	0	0	9
White Sands	0	0	0	0	0	0	3
Major Health Center							
Albuquerque	3	21	4	33	0	0	14
Belen	0	0	1	8	0	0	4
El Paso	2	14	0	0	3	25	52
Tucson	0	0	1	8	2	17	4
Phoenix	0	0	0	0	0	0	0
Safford/Springerville	0	0	0	0	0	0	1
Other	0	0	0	0	1	8	54
TOTAL RESPONSES		100%		100%		100%	

EXHIBIT B

RESIDENCE LOCATION BY MOST
FREQUENTLY GO FOR HEALTH/MEDICAL CARE
(Rural or Urban)

TOTAL SURVEY RESPONDENTS 400

Most Frequently Go	Rural, Urban Location				Total
	Rural		Urban		Combined
	F	%	F	%	
Nearest Large Population Center					
Total no. respondents *	214	54	180	46	394
Alamogordo	22	10	33	18	55
Carrizozo	0	0	0	0	0
Deming	16	7	11	6	27
Las Cruces	46	21	49	27	95
Lordsburg	5	2	2	1	7
Mescalero	2	1	4	2	6
Ruidoso	3	1	0	0	3
Silver City	21	10	25	14	46
Socorro	8	4	6	3	14
Truth or Consequences	5	2	4	2	9
White Sands	0	0	3	2	3
Major Health Center					
Albuquerque	9	4	5	3	14
Belen	4	2	0	0	4
El Paso	33	15	19	11	52
Tucson	4	2	0	0	4
Phoenix	0	0	0	0	0
Safford/Springerville	1	0	0	0	1
Other	35	16	19	11	54
TOTAL		100%		100%	

*Total excludes no responses

EXHIBIT C

137

Nearest Population Health Center/Services By Most Frequently Go For Health/Medical Care
(Continued on Following Page)

TOTAL SURVEY RESPONDENTS 400

Most Frequently Go

Nearest Large Population Center	Nearest Population Health Center Services											
	Las Cruces		Alamogordo		Silver City		Deming		Socorro		Truth Consequences	
	F	%	F	%	F	%	F	%	F	%	F	%
TOTAL NO. RESPONDENTS*	160	41**	90	23	50	13	32	8	29	7	16	4
Alamogordo	2	1	53	59	0	0	0	0	0	0	0	0
Carrizozo	0	0	0	0	0	0	0	0	0	0	0	0
Deming	2	1	0	0	1	2	23	72	0	0	1	6
Las Cruces	94	59	0	0	0	0	1	3	0	0	0	0
Lordsburg	0	0	0	0	0	0	1	3	0	0	0	0
Mescalero	0	0	1	1	0	0	0	0	0	0	0	0
Raidoso	0	0	2	2	0	0	0	0	0	0	0	0
Silver City	3	2	0	0	40	80	2	6	1	3	0	0
Socorro	0	0	0	0	0	0	0	0	14	48	0	0
Truth or Consequences	0	0	0	0	0	0	0	0	0	0	9	56
White Sands	3	2	0	0	0	0	0	0	0	0	0	0
Major Health Center												
Albuquerque	1	1	0	0	2	4	0	0	7	24	4	25
Belen	0	0	0	0	0	0	0	0	4	14	0	0
El Paso	36	22	10	11	0	0	4	13	0	0	2	13
Tucson	0	0	0	0	0	0	0	0	1	3	0	0
Phoenix	0	0	0	0	0	0	0	0	0	0	0	0
Safford/Springerville	0	0	0	0	1	2	0	0	0	0	0	0
Other	20	13	24	27	6	12	1	3	2	7	0	0
TOTAL RESPONSES		100%		100%		100%		100%		100%		100%

156

157

*Total excludes no responses

** Percent of total responses, 394

EXHIBIT C_1

133

Nearest Population Health Center/Services By Most Frequently Go For Health/Medical Care
(Continued)

TOTAL SURVEY RESPONDENTS 400

Most Frequently Go

Nearest Large Population Center	Nearest Population Health Center Services										
	Lordsburg		Mescalero		Carrizozo		Ruidoso		White Sands		Total
	F	%	F	%	F	%	F	%	F	%	
TOTAL NO. RESPONDENTS *	11	3	5	1	0	0	1	0	0	0	394
Alamogordo	0	0	0	0	0	0	0	0	0	0	55
Carrizozo	0	0	0	0	0	0	0	0	0	0	0
Deming	0	0	0	0	0	0	0	0	0	0	27
Las Cruces	0	0	0	0	0	0	0	0	0	0	95
Lordsburg	6	55	0	0	0	0	0	0	0	0	7
Mescalero	0	0	5	100	0	0	0	0	0	0	6
Ruidoso	0	0	0	0	0	0	1	100	0	0	3
Silver City	0	0	0	0	0	0	0	0	0	0	46
Socorro	0	0	0	0	0	0	0	0	0	0	14
Truth or Consequences	0	0	0	0	0	0	0	0	0	0	9
White Sands	0	0	0	0	0	0	0	0	0	0	3
Major Health Center											
Albuquerque	0	0	0	0	0	0	0	0	0	0	14
Belen	0	0	0	0	0	0	0	0	0	0	4
El Paso	1	9	0	0	0	0	0	0	0	0	52
Tucson	3	27	0	0	0	0	0	0	0	0	4
Phoenix	0	0	0	0	0	0	0	0	0	0	0
Safford/Springerville	0	0	0	0	0	0	0	0	0	0	1
Other	1	9	0	0	0	0	0	0	0	0	54
TOTAL RESPONSES		100%		100%		0%		100%		0%	

158

159

*Total excludes no responses

EXHIBIT D

FINANCIAL HEALTH PROTECTION BY HOUSEHOLD INCOME
(Continued on Following Page)

TOTAL SURVEY RESPONDENTS 400

Household Income	Financial Health Protection									
	Private Insurance		Work Insurance		Personal Resources		Medicare/ Medicaid		None	
	F	%	F	%	F	%	F	%	F	%
Total no. Respondents*	143	29**	139	28	101	20	61	12	37	7
Under $1,000 year	1	1	0	0	1	1	3	5	4	11
$1,001-3,000	12	8	8	6	25	25	16	26	11	30
$3,001-5,999	20	14	18	13	10	10	21	34	13	35
$6,000-8,999	33	23	31	22	13	13	7	11	6	16
$9,000-12,000	22	15	36	26	12	12	7	11	2	5
$12,001-15,000	12	8	17	12	8	8	1	2	0	0
$15,001-20,000	15	10	15	11	12	12	3	5	0	0
Over $20,000	28	20	14	10	20	20	3	5	1	3
TOTAL		100%		100%		100%		100%		100%

*Total includes multiple responses and excludes no responses.
**Percent of total responses, 498

EXHIBIT D_1

FINANCIAL HEALTH PROTECTION BY HOUSEHOLD INCOME
(Continued)

TOTAL SURVEY RESPONDENTS 400

Household Income

	Don't Know		Employees Disability Insurance		Assistance From Relatives or Friends		Religious Support		Total
	F	%	F	%	F	%	F	%	
Total no. respondents*	7	1	4	1	5	1	1	0	498
Under $1,000 year	0	0	0	0	1	20	0	0	10
$1,001-3,000	2	29	1	25	1	20	0	0	76
$3,001-5,999	2	29	0	0	0	0	0	0	84
$6,000-8,999	1	14	0	0	1	20	0	0	92
$9,000-12,000	0	0	1	25	1	20	1	100	82
$12,001-15,000	1	14	2	50	1	20	0	0	42
$15,001-20,000	0	0	0	0	0	0	0	0	45
Over $20,000	1	14	0	0	0	0	0	0	67
TOTAL		100%		100%		100%		100%	

*Total includes multiple responses and excludes no responses

EXHIBIT E

SOURCES CONSULTED FIRST FOR ESTABLISHING ILLNESS DIAGNOSIS BY RESPONDENT ETHNIC BACKGROUND
(Continued on Following Page)

TOTAL SURVEY RESPONDENTS 400

Ethnic Background	Sources									
	Physician		Relatives		Myself		Friends		Nurse	
	F	%	F	%	F	%	F	%	F	%
TOTAL NO. RESPONDENTS*	316	79 **	53	13	18	5	6	2	2	1
Spanish or Mexican-American, Mexican	113	36	21	40	5	28	1	17	0	0
Indian	3	1	6	11	1	6	0	0	0	0
Black	4	1	0	0	0	0	0	0	0	0
Anglo	192	61	26	49	12	67	5	83	2	100
Other	4	1	0	0	0	0	0	0	0	0
TOTAL RESPONSES		100%		100%		100%		100%		100%

*Total excludes no responses
**Percent of total responses, 399

EXHIBIT E_1

SOURCES CONSULTED FIRST FOR ESTABLISHING ILLNESS DIAGNOSIS BY RESPONDENT ETHNIC BACKGROUND
(Continued)

TOTAL SURVEY RESPONDENTS 400

Ethnic Background	Sources						
	Chiropractor		Pharmacist/Druggist		Self Treatment		Total
	F	%	F	%	F	%	
TOTAL NO. RESPONDENTS	2	1	1	0	1	0	399
Spanish or Mexican-American, Mexican	0	0	0	0	0	0	140
Indian	0	0	0	0	0	0	10
Black	0	0	0	0	0	0	4
Anglo	2	100	1	100	1	100	241
Other	0	0	0	0	0	0	4
TOTAL RESPONSES		100%		100%		100%	

EXHIBIT F

IMPORTANT SYMPTOMS USED IN DETERMINING ILLNESS BY ETHNIC BACKGROUND OF RESPONDENT
(Continued on Following Page)

TOTAL SURVEY RESPONDENTS 400

Ethnic Background	Symptoms									
	Fever		Aches Pains		Behavioral Habit Changes		Respiratory		Change in Attitude	
	F	%	F	%	F	%	F	%	F	%
Total no. responses	300	26**	198	17	193	16	154	13	144	12
Spanish or Mexican-American, Mexican	110	37	69	35	72	37	61	40	49	34
Indian	3	1	4	2	7	4	0	0	9	6
Black	2	1	6	3	2	1	2	1	0	0
Anglo	181	60	115	58	111	58	89	58	85	59
Other	4	1	4	2	1	1	2	1	1	1
TOTAL		100%		100%		100%		100%		100%

* Total excludes no responses
**Percent of total responses, 1176

EXHIBIT F_1

IMPORTANT SYMPTOMS USED IN DETERMINING ILLNESS BY ETHNIC BACKGROUND OF RESPONDENT
(Continued)

TOTAL SURVEY RESPONDENTS 400

Ethnic Background	Symptoms								
	Nausea		Change in Appearance		Pulse		Person Tells Me		Total
	F	%	F	%	F	%	F	%	
Total no. Responses	94	8	72	6	19	2	2	--	1176
Spanish or Mexican-American, Mexican	35	37	12	17	6	32	2	100	416
Indian	5	5	2	3	0	0	0	0	30
Black	0	0	0	0	0	0	0	0	12
Anglo	54	57	58	81	13	68	0	0	706
Other	0	0	0	0	0	0	0	0	12
TOTAL		100%		100%		100%		100%	

EXHIBIT G

HOUSEHOLD HEALTH ASSESSMENT BY REPORTED
NEED FOR MORE HEALTH EDUCATION/TRAINING

TOTAL SURVEY RESPONDENTS 400

Household Health Assessment

Reported Need For Training	Good		Excellent		Fair		Poor		Total
	F	%	F	%	F	%	F	%	
Total no. respondents	170	43	152	38	53	13	24	6	399
Yes	100	59	96	63	28	53	11	46	235
No	70	41	56	37	25	47	13	54	164
TOTAL		100%		100%		100%		100%	

EXHIBIT H

HOUSEHOLD SATISFACTION WITH HEALTH SERVICES/CARE
RECEIVED BY EDUCATION OF HOUSEHOLD HEAD

TOTAL SURVEY RESPONDENTS 400

Head of Household Education	Satisfaction: Very Satisfied		Partially Satisfied		Very Dis-Satisfied		Partially Dis-Satisfied		Total
	F	%	F	%	F	%	F	%	
Total no. Respondents*	266	70**	91	24	16	4	8	2	381
Professional	11	4	4	4	2	13	2	25	19
Four Year College Graduate	20	8	9	10	2	13	1	13	32
One-Three Years College	25	9	16	18	4	25	0	0	45
High School Graduate	76	29	21	23	2	13	0	0	99
Ten-Eleven Years School	27	10	12	13	1	6	1	13	41
Seven-Nine Years School	44	17	15	16	3	19	0	0	62
Under Seven Years School	63	24	14	15	2	13	4	50	83
TOTAL		100%		100%		100%		100%	

*Total excludes no responses
**Percent of total responses, 381.

EXHIBIT I

HOUSEHOLD SATISFACTION WITH HEALTH SERVICES/CARE
RECEIVED BY HOUSEHOLD INCOME

TOTAL SURVEY RESPONDENTS 400

Household Income	Satisfaction: Very Satisfied F	Very Satisfied %	Partially Satisfied F	Partially Satisfied %	Very Dis-Satisfied F	Very Dis-Satisfied %	Partially Dis-Satisfied F	Partially Dis-Satisfied %	Total
Total no. Respondents *	272	70 **	91	23	16	4	9	2	388
Under $1,000 a year	9	3	0	0	0	0	1	11	10
$1,001-3,000	47	17	16	18	2	13	1	11	66
$3,001-5,999	55	20	10	11	4	25	2	22	71
$6,000-8,999	50	18	20	22	1	6	1	11	72
$9,000-12,000	42	15	13	14	1	6	3	33	59
$12,001-15,000	19	7	12	13	2	13	0	0	33
$15,001-20,000	21	8	8	9	3	19	0	0	32
Over $20,000	29	11	12	13	3	19	1	11	45
TOTAL		100%		100%		100%		100%	

* Total excludes no responses
**Percent of total responses, 388

EXHIBIT J

HOUSEHOLD SATISFACTION WITH HEALTH SERVICES/CARE
RECEIVED BY ETHNIC BACKGROUND OF RESPONDENT

TOTAL SURVEY RESPONDENTS 400

Ethnic Background	Satisfaction: Very Satisfied		Partially Satisfied		Very Dis-Satisfied		Partially Dis-Satisfied		Total
	F	%	F	%	F	%	F	%	
Total no. Respondents *	281	71 **	92	23	16	4	9	2	398
Spanish or Mexican-American, Mexican	111	40	19	21	5	31	4	44	139
Indian	7	2	3	3	0	0	0	0	10
Black	4	1	0	0	0	0	0	0	4
Anglo	156	56	69	75	11	69	5	56	241
Other	3	1	1	1	0	0	0	0	4
TOTAL		100%		100%		100%		100%	

*Total excludes no responses

**Percent of total responses, 398

EXHIBIT K

HOUSEHOLD SATISFACTION WITH HEALTH SERVICES/CARE
RECEIVED BY RESIDENCE LOCATION

TOTAL SURVEY RESPONDENTS 400

Residence Location	Satisfaction: Very Satisfied		Partially Satisfied		Very Dis-Satisfied		Partially Dis-Satisfied		Total
	F	%	F	%	F	%	F	%	
Total no. Respondents*	281	71 **	92	23	16	4	9	2	398
Rural	155	55	50	54	9	56	4	44	218
Urban	126	45	42	46	7	44	5	56	180
TOTAL		100%		100%		100%		100%	

*Total excludes no responses
**Percent of total responses, 398

EXHIBIT L

HOUSEHOLDS REPORTING NEED FOR MORE HEALTH EDUCATION/TRAINING
BY PREFERRED MEANS OF EDUCATION

TOTAL SURVEY RESPONDENTS 400

Preferred Means	Need For More Education/Training	
	Yes	
	F	%
TOTAL NO. RESPONSES*	1026	100
Television and radio	207	20
Adult education courses	185	18
Newspapers and magazines	135	13
Special literature and pamphlets	136	13
Talks with friends or relatives	96	9
Educational movies	85	8
Contact at home by voluntary or public health organization workers	81	8
Lectures and discussions with people	58	6
Mobile educational van	36	4
Other	7	1
TOTAL		100%

*Total includes multiple responses and excludes no responses

EXHIBIT M

Households With Special/Recurrent Health Problems
By Reported Preference For Educational Means

TOTAL SURVEY RESPONDENTS 400

Preferred Educational Means	Special/Recurrent Health Problems				
	Yes		No		Total
	F	%	F	%	
TOTAL NO. RESPONDENTS*	275	27	751	73	1026
Adult Education Courses	55	20	130	17	185
Lectures and Discussions	10	4	48	6	58
Newspapers, Magazines	40	15	95	13	135
Special Literature and Pamphlets	31	11	105	14	136
Television and Radio	52	19	155	21	207
Educational Movies	16	6	69	9	85
Talks with friends/relatives	29	11	67	9	96
Contact at Home by Voluntary or Public Health Workers	33	12	48	6	81
Mobile Educational Van	6	2	30	4	36
Other	3	1	4	1	7
TOTAL		100%		100%	

*Total excludes no responses

EXHIBIT N

HOUSEHOLDS REPORTING NEED FOR MORE HEALTH EDUCATION/TRAINING
BY REPORTED TOPICS TO BE INCLUDED

TOTAL SURVEY RESPONDENTS 400

Topics to be Included	Need for More Education/Training	
	Yes	
	F	%
TOTAL NO. RESPONDENTS*	1740	100
General household health care	287	16
Emergency first aid	261	15
Homemaker, home nursing skills	153	9
Health care for elderly people	136	8
Dental hygiene	114	7
Follow-up care after illness	103	6
Nutrition (meal planning, diets)	96	6
Infant and child care	82	5
Disaster training (floods, fires, tornadoes, etc.)	88	5
Family planning (birth control)	66	4
Sanitation household practices (garbage, waste disposal)	61	4
Other	7	4
Services for the handicapped (including speech and hearing impairments)	55	2
Animal control and health	53	2
Insect control	60	2
Pre-natal care	43	2
Understanding and rehabilitation for military veterans	38	2
Health problems for migrant workers	37	2
TOTAL		100%

*Total includes multiple responses and excludes no responses

EXHIBIT O

REPORTED NEED FOR MORE HEALTH EDUCATION/TRAINING
BY EDUCATION OF HOUSEHOLD HEAD

TOTAL SURVEY RESPONDENTS 400

Head of Household Education	Need for More Education				Total
	Yes		No		
	F	%	F	%	
Total no. respondents *	226	59	155	41	381
Professional	13	6	6	4	19
Four Year College Graduate	15	7	17	11	32
One-Three Year College Graduate	27	12	18	12	45
High School Graduate	65	29	34	22	99
Ten-Eleven Years School	23	10	18	12	41
Seven-Nine Years School	39	17	23	15	62
Under Seven Years School	44	20	39	25	83
TOTAL		100%		100%	

*Total excludes no responses

EXHIBIT P

REPORTED NEED FOR MORE HEALTH
EDUCATION/TRAINING BY HOUSEHOLD INCOME

TOTAL SURVEY RESPONDENTS 400

Household Income	Need for More Education				Total
	Yes		No		
	F	%	F	%	
Total no. respondents*	229	59	159	41	388
Under $1000 year	1	0	9	6	10
$1001-3,000	37	16	29	18	66
$3,001-5,999	39	17	32	20	71
$6,000-8,999	46	20	26	16	72
$9,000-12,000	37	16	22	14	59
$12,001-15,000	22	10	11	7	33
$15,001-20,000	21	9	11	7	32
Over $20,000	26	11	19	12	45
TOTAL		100%		100%	100%

*Total excludes no responses

EXHIBIT Q

REPORTED NEED FOR MORE HEALTH EDUCATION/TRAINING
BY ETHNIC BACKGROUND OF RESPONDENT

TOTAL SURVEY RESPONDENTS 400

Ethnic Background	Need for More Education				Total
	Yes		No		
	F	%	F	%	
Total no. respondents *	234	59	165	41	399
Spanish or Mexican-American, Mexican	82	35	58	35	140
Indian	4	2	6	4	10
Black	2	1	2	1	4
Anglo	144	62	97	59	241
Other	2	1	2	1	4
TOTAL		100%		100%	

* Total excludes no responses

EXHIBIT R

REPORTED NEED FOR MORE HEALTH EDUCATION/TRAINING
BY RESIDENCE LOCATION

TOTAL SURVEY RESPONDENTS 400

Residence Location	Need for More Education				Total
	Yes		No		
	F	%	F	%	
Total no. respondents	235	59	165	41	400
Rural	141	60	79	48	220
Urban	94	40	86	52	180
TOTAL		100%		100%	

SECTION D

HEALTH MANPOWER, RURAL HOUSEHOLDS

Exhibit V_1

SOURCES	F	%
M.D. Family Doctor (G.P.)		
Should have more doctors available, doctors not available when needed	9	9
Do not take enough interest, need dedicated doctor	8	8
Should not have to wait so long to be seen--reduce patient load	8	8
Need younger doctor; he is up in age, forgets, getting too old	4	4
Diagnosis was wrong and wrong medication prescribed	4	4
Should not charge so much, too expensive	3	3
More experience (needs doctors with more years in the profession)	3	3
Poor facilities, improvement would help	2	2
Exam should be done by doctor--should not turn patient over to nurse (patient not examined by doctor, instead handled by a very discourteous nurse)	1	1
Exams are not thorough enough	1	1
Need other referral services; went to doctor several times for burned knee, then went to other doctor and got prompt relief. The first doctor should know his own capabilities and refer without loss of time and without causing the need for two fees.	1	1
You never get the same one (should ask for same doctor)	1	1
The U. S. should go on socialized medicine	1	1
M.D. Specialist		
Inexperienced	1	1
Should not use scare tactics in front of heart patient. Scare tactics are not the way to counsel patients	1	1
Should have more communication with patient	1	1
We need a better attitude from M. D.	1	1

Exhibit V_2

SOURCES	F	%
Osteopath		
Should do a more thorough exam. Should examine patient before deciding what to prescribe	7	7
Should not give shots merely upon patient's request	1	1
The medicine she gets does not cure her (should change medication)	1	1
Do not take enough interest (need dedicated doctor)	1	1
They should not charge so much for such a rapid exam or manipulation	1	1
He should not allow patient to tell him what is wrong with him. Doctor should establish diagnosis himself instead of letting patient do his own. Listen to patient, yes, but then practice medicine properly	1	1
Should not require patient to keep going back; it is very expensive	1	1
Needs more training	1	1
Chiropractor		
Not enough attention to patient. Should not be in a hurry. Exam is very superficial. He appears to be in hurry to next patient	3	3
Need to check with another specialist	2	2
Need for better follow-up	2	2
Needs more training	1	1
Midwife		
Lady very old and nervous (needs younger midwife)	1	1
Curandero		
Should not charge so much	1	1
Dentist		
Too expensive; charge too much for quality of service. Should stick to fee agreed upon. Was given estimate, then when work was completed, the bill was considerably higher than agreed upon	8	8

Exhibit V_3

SOURCES	F	%
Dentist (cont.)		
Need more dentists, office overcrowded, takes about six weeks to get an appointment	7	7
Poor dental quality. Spend more time in preparing filling. A very expensive filling came off after two weeks and having rework alone was very painful	3	3
Not enough experience	2	2
Pulled more teeth than he should (need good doctor)	1	1
Too far to go (needs doctor in area)	1	1
Very informal	1	1
Move to a larger facility	1	1
He should be more punctual	1	1
Optometrist		
Should see another doctor or ophthalmologist, poor results	3	3
Expens[illegible]	2	2
Should [illegible]e so difficult to get an appointment	1	1
Ophthalmologist (M.D. eye doctor)		
Should have more ophthalmologists	2	2
Comes to Alamogordo every four months from Albuquerque (need ophthalmologist in Alamogordo)	1	1
Druggist (Pharmacist)		
Charge less; expensive	8	8
Use generic, not brand name	1	1
He tells us what to do, but patient should see a doctor	1	1
Employees have a poor attitude	1	1
Nurse (including school and public health)		
It is too bad they are not permitted to treat children	1	1

RESIDENT SUGGESTIONS

HEALTH MANPOWER, RURAL HOUSEHOLDS

Exhibit V_4

SOURCES	F	%
Physician's assistant/paraprofessional		
They need to hire more experienced personnel	1	1

TOTAL RESPONDENTS: 99

* Percentage total does not equal 100% due to multiple response.

RESIDENT SUGGESTIONS

HEALTH MANPOWER, URBAN HOUSEHOLDS

Exhibit V_5

SOURCES	F	%
M.D. Family Doctor (G.P.)		
Need more thorough exam; office exam too superficial. They need to be more understanding. (I know what I feel, they don't)	14	16
Better system needed; doctor appears overworked, get more professional help, too long a wait	12	15
Need a specialist. Not a very efficient doctor	5	6
Doctor should not require patients to keep going back (if doctor could treat illness in one visit, would be less expensive)	4	5
Not enough nurses to do required duties and assist	3	4
More communications with patient	3	4
Needs more experience	3	4
Should be less expensive	2	2
Need for more competent follow-up	2	2
Better bedside manners	1	1
They should not be annoyed when telephoned by a patient	1	1
Should be more careful in prescribing	1	1
Always a different one (should ask for same doctor)	1	1
They should have a nice attitude	1	1
Should not ask so many questions	1	1
More interest in children	1	1
M.D. Specialist		
Should pay more attention to patient	2	2
Is always a different one (should ask for same doctor)	1	1
Osteopath		
Should take more time to discuss illness with patient	2	2
Too expensive	1	1

Exhibit V_6

SOURCES	F	%
Chiropractor		
Needs additional follow-up; should spend more time with patient; take more interest in patient, need more discussion with patient	8	10
Need bone specialist	1	1
Dentist		
Need better quality work	6	7
Very expensive	4	5
Should not have left town without notifying patients. Patients reported for their appointments to an empty office	2	2
Need more dentists	2	2
He should have his own facilities	1	1
Should have office clean, looks unsanitary	1	1
Should not have to wait so long for appointment	1	1
On one or two occasions, I consulted local man who is not very active anymore	1	1
Should be more concerned	1	1
Optometrist		
Should not be so rude	2	2
They should give her bifocals	1	1
Too expensive	1	1
Need more thorough examination	1	1
Ophthalmologist (M.D. Eye Doctor)		
Should not have to go out of town for certain items	1	1
Druggist (Pharmacist)		
Should not charge too much; should have lower prices	3	4
Should be labeled in everyday language instead of by RX number	1	1

HEALTH MANPOWER, URBAN HOUSEHOLDS

Exhibit V_7

SOURCES	F	%
Nurse (Including School and Public Health)		
Should counsel students more	1	1

TOTAL RESPONDENTS: 82

* Percentage total does not equal 100% due to multiple responses.

RURAL HOUSEHOLDS

Exhibit V_6

FACILITIES/SOURCES	F	%
City, County, Community Hospital		
Overcrowded, understaffed (enlarge hospital and hire more help)	9	13
Very expensive, made it difficult to pay	5	7
Need better trained, competent personnel	5	7
Poor food	2	3
Need improved service, less waiting	2	3
Attitude of nurse could be better	1	1
Informant thinks hospital lacks professionalism	1	1
Improved quality of treatment	1	1
Need more RN's	1	1
Medication should be more closely supervised	1	1
Take fewer blood samples	1	1
Unfair to have to pay for parking	1	1
Private and/or Religious Hospital		
Need better attitude	1	1
Bring fees down to where everyone can pay	1	1
Neighborhood or Population Center Health Clinic		
Should be less expensive	3	4
Better organization of staff; not enough attention to patients. The whole atmosphere does not appear business like	2	3
Not enough doctors	1	1
Should be more careful in diagnosis and treatment (sister was not examined for chest pains on Saturday p.m., because it was closing time. Patient died that evening. Doctor in obvious hurry to get out and did not even examine the patient. Instead, he said, "You know we'll be open Monday, a.m.")	1	1
Nursing Home, Home for the Aged		
Need friendly dedicated nurses	1	1
Need better organization, everybody gives orders. Nobody seems to know who does what	1	1

RESIDENT SUGGESTIONS

RURAL HOUSEHOLDS

Exhibit V 9

FACILITIES/SOURCES	F	%
Ambulance		
Too slow in responding; dependable service needed	3	4
Military Hospital/Facilities or Veteran's Administration Facilities		
Need fewer interns and more experienced doctors	1	1
Felt he was not given enough attention	1	1
Waited too long	1	1
Drugstore		
Very expensive, should not cost so much	7	10
Use generic name, not brand	1	1
Physician, Dentist, etc. Office		
Should have more help. Need more help so doctor won't have to hurry	4	5
Not enough doctors	4	5
Waited too long	2	3
Need for lower cost	2	3
Doctor should examine first before granting patient's request for a shot; he should not be told what shot patient wants	2	3
Need more policing of M.D.'s by some authority	1	1
Better work quality	1	1
Should be more conscientious	1	1
Hospital Emergency Room		
Need faster, quality, efficient service. Too long a wait	12	17
Need more doctors	2	3
Charge less	1	1
Need more helpful nurses	1	1
Doctor should examine patient instead of prescribing over phone	1	1
Need more attention	1	1
Need better attitude	1	1

TOTAL RESPONDENTS: 70

* Percentage total does not equal 100% due to multiple responses.

URBAN HOUSEHOLDS

Exhibit V_{10}

FACILITIES/SOURCES	F	%
City, County, Community Hospital		
Need more professional personnel, better doctors	14	23
Should be better organized; should not put patient with emotional problems together with patient with broken wrist	5	8
They should improve their facilities	3	5
Should have more nurses to give better attention, should hire more nurses	3	5
Need more qualified dieticians	2	3
Request patients to sign blank statements without itemizing first	1	2
Nurses should obey doctor's orders	1	2
Fewer changes in attendants and other personnel	1	2
Private and/or Religious Hospital		
Need more competent help	1	2
Bureau of Indian Affairs or United States Public Health Service Clinic		
Doctor at local hospital very impatient with us. Informant said (through interpreters) that a U.S.P.H.S. doctor appears impatient and annoyed because Navajos don't answer questions readily. Claims patients don't understand the doctor	1	2
Neighborhood or Population Center Health Clinic		
Should not have to wait so long	1	2
Personnel should pay more attention to patients	1	2
Nursing Home, Home for the Aged		
Attendants and nurses should provide more attention	1	2
Should have recreational facilities	1	2

URBAN HOUSEHOLDS

Exhibit V_{11}

FACILITIES/SOURCES	F	%
School Nurses Office or Clinic		
Should have the same personnel always	1	2
Military Hospital/Facilities or Veteran's Administration Facilities		
Need better quality of physician care, poor attitude of doctor	2	3
Drugstore		
Should not charge such high prices	4	6
Should label bottles as to contents	1	2
Too much waiting	1	2
They should have delivery service	1	2
Should get correct prescription information	1	2
Our Home		
Improved cleanliness and sanitation	1	2
Physician, Dentist, etc. Office		
Should not be so crowded	11	18
Should give more attention to patient. They are in a hurry to get rid of you. Exams are superficial, if any. Should try to solve patients medical problems, more office time	6	10
Doctor's fees are too high	2	3
Need better filing and office organization; lost informant's family medical records	2	3
Should not be necessary to make repeated visits to physician's office	1	2
Receptionist shouldn't be so rude (should be polite, courteous receptionist)	1	2
Physician should show more courtesy towards patients; many times doctors appear to resent patients and sound discourteous in their tone of voice.	1	2
Should not be necessary to wait so long	1	2
Should have more doctors; M.D. is way past retirement age and is also overworked	1	2

RESIDENT SUGGESTIONS

URBAN HOUSEHOLDS

Exhibit V_{12}

FACILITIES/SOURCES	F	%
Hospital Emergency Room		
They should not be so slow, should not keep people waiting so long	5	8
Should have more interest and provide the patient more attention	5	8
Improved management and cleanliness of facilities	3	5
Fewer personnel changes among attendants	1	2
Doctor should not take so long to arrive. They generally have trouble locating a doctor to attend the emergency room	1	2

TOTAL RESPONDENTS: 62

* Percentage total does not equal 100% due to multiple responses.

RURAL HOUSEHOLDS

Exhibit V13

CONDITIONS/SITUATIONS	F	%
Accidents/broken bones		
Need more personnel	4	6
Need better quality treatment	3	4
Service too slow, shouldn't have to wait so long	2	3
Nurse's aide should not use profanity. RN's are discourteous and appear to dislike Mexicans	1	1
Charged too much for quality of services	1	1
Physician should have been more concerned	1	1
X-rays should not take so long. Instances where X-rays have to be sent to El Paso for developing When returned one has trouble getting hold of doctor to have them read	1	1
Burns		
Doctor herself should not take so long to be seen	1	1
Improved physician understanding. A doctor should realize that a farmer coming from the field directly to the doctor will have dirty hands. Patient should not be expected to wash hands with soap and water, especially if he is in pain from burns.	1	1
Infectious Diseases (Measles, Mumps)		
Should not have to wait so long, too slow	2	3
More thorough diagnosis needed	1	1
Minor Surgery (Cyst and Wart Removal, etc.)		
They are very expensive, should not charge so much	2	3
Physician needs more interest in patient	1	1
Better hospital service	1	1
Need pathologist or specialist to explain diagnosis	1	1
Medication should be closely supervised. Patient was given wrong medication	1	1
Physician should explain diagnosis	1	1

RURAL HOUSEHOLDS

Exhibit V
14

CONDITIONS/SITUATIONS	F	%
Major Surgery (Hysterectomy, etc.)		
Less expensive	2	3
Need for more considerate, polite treatment	1	1
Respiratory (T.B., Emphysema, Pneumonia)		
Should not have to wait so long to be seen	1	1
Need larger staff	1	1
Less exorbitant cost for treatment (physician and hospital)	1	1
Cancer and Terminal Illness		
Lower prices	1	1
Need for specialist	1	1
Need more time	1	1
Out-Patient Laboratory Work (blood sample, urinalysis)		
Less expensive	3	4
Need for doctor to explain results	1	1
Receive correct medication	1	1
Should not take so long to see doctor, then only three minutes for test	1	1
They could have eliminated duplicates of tests to save me money. (When lab tests are done in one agency and then there is a referral lab, results should be forwarded also, thereby eliminating extra expense upon duplication of tests)	1	1
Family Planning Services (Birth Control, etc.)		
Better explanation, better trained personnel	1	1
Chiropractic Adjustments		
More thorough exam instead of concern about insurance coverage (they ask more questions about this type of insurance rather than symptoms, physical complaints, etc.)	3	4

RURAL HOUSEHOLDS

Exhibit V_{15}

CONDITIONS/SITUATIONS	F	%
Chiropractic Adjustments (continued)		
Needs to examine patients more thoroughly instead of just neck popping; more time with patient	2	3
Reduced charge	1	1
Need more training (doctor was rough during neck manipulation, which showed he was not a professional. A well-trained chiropractor would be more gentle)	1	1
Mental/Emotional/Drugs/Alcohol		
More effective therapy	1	1
Toothache/Tooth Repair		
Prices too high	6	8
Get some more dentists	4	6
Should not take six weeks to get an appointment	2	3
More attention	1	1
Should be more gentle	1	1
Higher quality work	1	1
Too far to travel	1	1
False Teeth		
Need better fit, correction from dentist; should be able to make them fit right	2	3
Should not take so long for appointment	1	1
Colds and/or Flu Virus		
Doctor should have more help	7	10
Should examine patient before giving a shot	5	7
Need more doctors to avoid long waits	2	3
Needed more effective medication	1	1
More attention and fewer repeat visits	1	1
Needed other medication, non-allergic	1	1

RESIDENT SUGGESTIONS

RURAL HOUSEHOLDS

Exhibit V-16

CONDITIONS/SITUATIONS	F	%
"Susto"		
More understanding of condition by physician	1	1
Glasses, Contact Lenses		
Need a better fit	2	3
Should not take so long to ship glasses from El Paso	1	1
Reduced waiting for appointment	1	1

TOTAL RESPONDENTS: 71

* Percentage total does not equal 100% due to multiple responses.

URBAN HOUSEHOLDS

Exhibit V-17

CONDITIONS/SITUATIONS	F	%
Accidents/Broken Bones		
They should improve their service, somehow. Show increased assistance when patient is trying to eat or bathe	3	8
Bone reset incorrectly	2	5
Nurses appear confused and not well-organized	1	2
Fee should not be so much	1	2
Minor Surgery (Cyst and Wart Removal, etc.)		
Pathologist available when needed	1	2
Should not take so long to be seen	1	2
Cleaner facilities	1	2
Major Surgery (Hysterectomy)		
Better management and organization among personnel	4	10
More attention to duties by nurses	2	5
Physician should not scare patient before surgery by discussing death	1	2
Personnel should be more concerned for patient	1	2
Respiratory (T.B., Emphysema, Pneumonia, etc.)		
Should have better meals	1	2
They should be more accurate in diagnosis	1	2
Should give more attention to patients without being in a hurry	1	2
Cancer and Terminal Illness		
Immediate treatment	1	2
Out-Patient Laboratory Work (blood sample and urinalysis)		
Should be able to take and provide test results the same day	3	8

Exhibit V
18

CONDITIONS/SITUATIONS	F	%
Chiropractic Adjustments		
Need additional adjustments	1	2
Toothache/Tooth Repair		
Very expensive, prices should be more reasonable	5	12
Better quality work and more patient attention	1	2
False Teeth		
Charge too much	2	5
He should be able to fit them right	1	2
Colds and/or Flu Virus		
Should not have to wait so long for treatment	4	10
Should not take so many tests for a simple cold	2	5
Should show better attitude towards patients. There is no friendly relationship between doctors and patients any more. U.S.P.H.S.(doctor) clinic on reservation yells too much, as if he were mad	2	5
Should have more help	1	2
Should be better organized in keeping patient records	1	2
More personal attention	1	2
Should not prescribe shots merely on patient's complaints; should examine patient thoroughly	1	2
"Susto"		
Additional attention to understand and cope with shock	1	2
Glasses, Contact Lenses		
Should have glasses fit on first visit	1	2
Reduced cost and economic assistance to buy glasses	1	2

TOTAL RESPONDENTS: 40

* Percentage total does not equal 100% due to multiple responses.

RESIDENT SUGGESTIONS

RURAL AND URBAN

Exhibit V 19

RURAL — PREVENTATIVE SERVICES	F	%
Vaccination, Innoculation		
Reduce risk of a bad reaction	1	14
Nutrition and Foods		
Additional explanations of topic	1	14
Diagnostic (T.B. X-ray, T.B. Patch, Pap Smear, Diabetic Urinalysis Detection)		
Need for correct diagnosis, better trained diagnosticians	1	14
Less waiting time for X-rays	1	14
Annual or Regular Physical Examination		
Spend more time, more thorough checkup; needs to do more thorough exam. Too much of a hurry on the doctor's part	2	29

TOTAL RESPONDENTS: 7

* Percentage total does not equal 100% due to rounding off of figure.

URBAN		
Diagnostic (T.B. X-ray, T.B. Patch, Pap Smear, Diabetic Urinalysis Detection)		
Need for closer doctor/patient relationship	1	100

TOTAL RESPONDENTS: 1

RURAL AND URBAN

Exhibit V
20

RURAL — PRENATAL AND CHILD CARE SERVICES	F	%
Prenatal Services		
No pediatrician in Alamogordo	1	33
Distance too great	1	33
Need more communications (Mother did not receive postnatal exams)	1	33
Delivery		
Need doctor in the area	1	33
Postnatal, Pediatric, and Child Health Care		
Child should have received more checkups and follow-up. No more appointments were made after child was born	1	33

TOTAL RESPONDENTS: 3

URBAN	F	%
Prenatal Services		
Should have more help from health care personnel	1	13
Should do pelvic exam during pregnancy	1	13
Should be more concerned	1	13
Delivery		
Should have more help, personnel assistance	1	13
Postnatal, Pediatric, and Child Health Care		
Need a pediatrician in the area	6	75

TOTAL RESPONDENTS: 8

* Percentage total does not equal 100% due to multiple responses.

SECTION E

REASONS FOR SATISFACTION OR DISSATISFACTION
WITH HEALTH/SERVICES CARE RECEIVED

Albuquerque*

RURAL

Satisfied:	F	%
Good results. Pleased with services. We get good service	3	33
We are in reasonably good health	1	11
I don't need a doctor	1	11
We've always received good medical and health care in Albuquerque	1	11
Dissatisfied:		
We prefer Albuquerque, but it is still too far	1	11
We don't fool with services in the area, we go to Albuquerque	1	11
Doctors take the patient's word for what ails them. He allows them to request their own medication	1	11

TOTAL RESPONDENTS: 9

URBAN

Dissatisified:		
All our needs are taken care of	2	40
In Albuquerque they give me very good treatment	1	20
Dissatisfied:		
We need more specialists	1	20
We don't have competent doctors like big cities	1	20

TOTAL RESPONDENTS: 5

*Located outside of Southwestern consortium

Exhibit S2

REASONS FOR HEALTH SERVICES/CARE
SATISFACTION AND DISSATISFACTION

Alamogordo

RURAL

Satisfied:	F	%
We get cured when we need it	2	8
Except for my husband's condition, which is being observed in Albuquerque, all our other needs are taken care of here, locally	2	8
For what litte we go, it is fine	2	8
We've been lucky in that we have encountered no problems regarding our medical and health needs	1	5
I have been to the doctor only once in the last five years	1	5
We get our needs well taken care of. For big things, like my gall bladder operation, we go to Albuquerque, my wife's home	1	5
Most of our needs have been major, so we go	1	5
We get good service in El Paso for big things. Alamogordo is OK for minor things	1	5
The doctor is OK I guess considering the number of people he has to see	1	5
Has done good	1	5
Physician has given her confidence	1	5
They have taken me in right away	1	5
Got good attention	1	5
I'm satisfied; I think he does his best	1	5
They are OK	1	5
Dissatisfied:		
Lack of doctors	3	14
They should take more time with each patient	1	5

TOTAL RESPONDENTS: 22

Exhibit S2

Alamogordo (continued)

URBAN

Satisfied:	F	%
I think they are perfect--have excellent doctors. The doctors and dentists are all excellent.	3	9
For what little use I've had, it is alright	1	3
I have always received very good medical service	1	3
The intern is excellent; have no complaints	1	3
He is very good and helps us	1	3
I have complete confidence; he always finds time to talk to you	1	3
We have not had enough sickness to judge	1	3
Anytime we have taken household members for attention, they have been prompt	1	3
He does the best he can	1	3
No complaints	1	3
The doctor cured me of dizziness	1	3
They are always nice to us	1	3
He has been our doctor since we came here, and has always cured us. We have faith in him	1	3
The doctors are very good	1	3
They have been fine whenever I have gone	1	3
Has no complaints; has always been taken care of	1	3
They are really good people	1	3
When the doctor has prescribed, it has helped	1	3
He has not had any troubles diagnosing us	1	3
They take interest	1	3
They are alright	1	3
They have always gotten me over what I have, the few times I have gone	1	3
We have excellent doctors	1	3
They take care of my kids, I have faith in them	1	3
Good personal attention	1	3
Dissatisfied:		
Incompetent and inefficient receptionist	2	6
Doctors are not dedicated at all	1	3
Service is alright, but they should be more concerned	1	3
They should be able to provide better facilities and have a staff that knows what they are doing	1	3

TOTAL RESPONDENTS: 32

SERVICES SATISFACTION/DISSATISFACTION

Belen

RURAL

Satisfied:	F	%
Our needs have been taken care of	1	33
Dissatisfied:		
Farmers and ranchers can't afford to waste too much time waiting at the doctor's or dentist's offices	1	33
When we go to the doctor, we have to hope to be seen that day	1	33

TOTAL RESPONDENTS: 3

URBAN

Satisfied:		
We have known the Belen doctor for many years, so have our families	1	100

TOTAL RESPONDENTS: 1

*Located outside of Southwestern consortium.

SERVICES SATISFACTION/DISSATISFACTION

Carrizozo *

RURAL

Satisfied:	F	%
I've had good service although I don't get sick often	1	100

*Located outside of Southwestern consortium

SERVICES SATISFACTION/DISSATISFACTION

Deming

RURAL

Satisfied:	F	%
I take care of myself. My health is good; I seldom go to the doctor	3	20
We have had our needs taken care of	2	13
They always seem to get well with what medicine they get	1	7
We have good care generally. We can put up with these small annoyances, a local hospital supplies many major medical needs	1	7
Since we have found Jesus, we have few complaints	1	7
We have a good family doctor (friend of the family)	1	7
Dissatisfied:		
Need more doctors.	4	27
Lack of attention, too much hurry-up on the part of the doctors	1	7
We need more doctors to expedite services Present doctor is leaving and appears overworked	1	7
Better referral service. If doctor can't treat the ear, he should say so	1	7
Need X-ray service in Deming. Las Cruces is too far; also need a urologist	1	7

TOTAL RESPONDENTS: *15

URBAN

Satisfied:		
We have been taken care of for years	3	33
For what little they have needed medical aid, they always get good attention	2	22
I like the doctors, they have been nice. Know what they are doing	1	11
They keep him alive	1	11
Not enough time to evaluate accurately	1	11

*Total includes multiple responses.

Exhibit 8)

Deming (continued)

URBAN

Satisfied:	F.	%
Every time she goes, she gets first rate attention	1	11
They are thorough	1	11
Dissatisfied:		
Too expensive, do not take enough time; not a thorough enough exam	1	11
There are no specialists, not enough good facilities	1	11

TOTAL RESPONDENTS: *9

*Total includes multiple responses

SERVICES SATISFACTION/DISSATISFACTION

El Paso*

RURAL

Satisfied:	F.	%
We get good service in El Paso. We go to El Paso most of the time and they have always helped us	10	31
They have been very helpful	6	19
They always show interest	2	7
We think it is OK	2	7
So far they have gotten along fine without any complications	1	3
Because they have always had a complete exam and treatment	1	3
Has been treated alright with what little experience they have	1	3
We have always gotten results except for Las Cruces emergency room	1	3
They seem to diagnose the illness alright	1	3
I am in good health; so was my wife during her lifetime	1	3
We make our appointments to coincide with our trips to El Paso; no trouble getting to see doctor	1	3
The doctors have been very good to us	1	3
Dissatisfied:		
Because fees (doctor & hospital) are so high that no insurance covers all, one still has to dig into the pocket and that ruins many people	2	7
He has no faith in M.D.	1	3
All our needs are taken care of. The only annoying thing is the waiting	1	3

TOTAL RESPONDENTS: 32

URBAN

Satisfied:		
El Paso has good medical service	4	25
We can get any medical services worth the money we pay	1	6
We always get well when we have gone to see them	1	6

*Located outside of Southwestern consortium.

Exhibit 86

El Paso (continued)

URBAN

Satisfied:	F	%
We know the doctors in El Paso and our frequent trips there make it more convenient	1	6
We have a wonderful eye doctor in El Paso	1	6
The eye surgeon was great; the patch isn't off, but I can already see through the perforation	1	6
When necessary, my daughter takes me to the doctor in El Paso	1	6
Dissatisfied:		
Once we get to El Paso, the service is good; but the distance is an inconvenience	1	6
The doctor had to operate a second time, therefore, it is not satisfactory	1	6
It is very good, the bad thing is that we have to go so far	1	6
Doctors experiment too much. They just want more money, so they have you come back	1	6
They charge too much	1	6
We need more doctors	1	6

TOTAL RESPONDENTS: 16

Exhibit S7

Las Cruces

RURAL

Satisfied:	F	%
We get good attention	7	17
Very satisfied with what little I've had to use them	6	15
Very satisfied with doctors; about as good as any	4	10
We always get well	2	5
He was very thorough	2	5
Feels that the doctor is interested in their health problems	1	3
Always received prompt treatment	1	3
We hardly ever need it	1	3
I feel better than I did	1	3
They are doing what they know best	1	3
We don't know since we have not used them since we have been here	1	3
The doctor explains exactly what's wrong with you	1	3
He has been her doctor for a long time	1	3
Dissatisfied:		
If only they were not so expensive	4	10
They should have better doctors in Las Cruces	3	8
They are always rushing	1	3
Maybe I am too demanding, but doctors don't seem as concerned these days	1	3
They could improve it	1	3
Has not been that sick to run into the shortage of staff encountered	1	3

TOTAL RESPONDENTS: * 39

URBAN

Satisfied:		
All our needs are taken care of	7	15
We have no problems with service	5	11
We are in good health	4	9
We seldom get sick	3	7
Only God can cure all	1	2

*Includes multiple responses

Las Cruces (continued)

URBAN

Satisfied:	F	%
We get reasonably good service	1	2
We don't have any trouble getting medical attention, but I notice that the Americans are very important; they want a doctor right away	1	2
Because I'm the only one that has been in the hospital and then only for a short period	1	2
We're lucky to find good doctors	1	2
My condition is dealt with the best way they can	1	2
I have a good doctor	1	2
I go to the doctor for medication, but not to be starved with silly diets	1	2
We have faith in our doctor	1	2
There is hope because they discovered cancer before it was too late	1	2
Dissatisfied:		
I don't think that the doctors are very competent	3	7
Fees and cost of medicine is now beyond the reach of the average person	3	7
There is nothing else to do for arthritis and high blood pressure	1	2
Except for the attitude displayed by the help toward the patients	1	2
Should not try to get rid of patients so quickly	1	2
The doctors do what they are supposed to, but with all this trash around us (roaches, dirty dishes, spilled dog food, etc., how can we be in good health)	1	2
Offices too crowded	1	2
My medicine and S.S. payments are not enough for me	1	2
We have a friend who works for a doctor and she gets us in when we need to	1	2
One has to live with arthritis, but other than that, we are in good shape	1	2
Can't get a specialist in the middle of the night	1	2

Exhibit S7

Las Cruces (continued)

URBAN

Dissatisfied:	F	%
Not enough assistance to disabled patient	1	2
My gynecologist did not discover I had a tumor	1	2
Too much confusion and arguing before deciding what to do with patients, especially at the hospital	1	2
More competency	1	2
Need more technicians	1	2
I cannot afford even follow-up exam on treatment	1	2
Need more personal attention and more thorough exam from the doctor	1	2

TOTAL RESPONDENTS: *46

*Total includes multiple responses

SERVICES SATISFACTION/DISSATISFACTION

Lordsburg

RURAL

Satisfied:	F	%
We never get sick, so we have no complaints	1	20
We have had our needs supplied	1	20
Dissatisfied:		
Doctors should have more communication with patient. Too much hurrying	1	20
The distance for specialists is too great. Someone should do something to attract specialists to the area	1	20
Aids need more close supervision for maximum efficiency	1	20

TOTAL RESPONDENTS: 5

URBAN

Satisfied:		
I have no reason to be unhappy. He has always taken care of me	1	50
Except for an experience of a wrong diagnosis we are generally in good health	1	50

TOTAL RESPONDENTS: 2

Exhibit S9

SERVICES SATISFACTION/DISSATISFACTION

Mescalero *

RURAL

Satisfied:	F	%
My family gets good care at the U.P.H.S. Hospital	1	50
Dissatisfied:		
We have good medical care except for eye care. Doctor doesn't come often enough	1	50

TOTAL RESPONDENTS: 2

URBAN

Satisfied:		
Hardly ever go to know for sure	1	25
We have good facilities. They have taken members of my family as far as William Beaumont in El Paso	1	25
Dissatisfied:		
I can't stop drinking	1	25
We need an eye doctor to come more than once a month	1	25

TOTAL RESPONDENTS: 4

*Located outside of Southwestern consortium.

Exhibit S10

SERVICES SATISFACTION/DISSATISFACTION

Ruidoso

RURAL

Satisfied:	F	%
We have received very good attention	1	50
We are in good health	1	50

TOTAL RESPONDENTS: 2

*Located outside of Southwestern consortium

SERVICES SATISFACTION/DISSATISFACTION

Safford/Springerville

RURAL

Satisfied:	F	%
We don't get sick often	1	100

TOTAL RESPONDENTS: 1

*Located outside of Southwestern consortium

Exhibit S12

SERVICES SATISFACTION/DISSATISFACTION

Silver City

RURAL

Satisfied:	F	%
We think we've received good service	2	15
We take care of our own illnesses. In case of anything major, we'd go to El Paso	1	7
We don't use doctors very much. The few times we've used one, we received reasonable service	1	7
We've no special problems, because we stay healthy	1	7
Dissatisfied:		
The cost is beyond many people's reach. We would go more often but we want to avoid the cost	3	21
There are not enough doctors; patients wait too long to be seen once you're in the waiting room	2	15
We've received good service, but the distance to get to the specialist is not always within reach of everyone	1	7
They always take care of our needs, although we stay as long as two days in Silver City because we have to wait	1	7
Dentist office too crowded; takes too long to get an appointment	1	7
Ranchers have to make a day of a visit to the doctor; too much waiting for appointments and service	1	7

TOTAL RESPONDENTS: 14

URBAN

Satisfied:		
All our needs are taken care of; good service	5	18
I have always received good attention	4	14
For the few times we have needed one, he's alright	2	7

SERVICES SATISFACTION/DISSATISFACTION

Silver City (continued)

URBAN

Satisfied:	F	%
They always seem to diagnose right	1	4
They do their best, we are not very demanding	1	4
Yes, the doctors for Kennecott are excellent and give us good medical attention	1	4
The doctors in Silver City are alright when we go out there	1	4
We seldom get sick	1	4
Dissatisfied:		
Too much waiting	3	11
I get very good attention from the doctors, but they have poor facilities	3	11
They are OK, but it is impossible for them to give individual attention to everyone; need more doctors	2	7
The doctor's help is not efficient	2	7
Need for a pathologist. Sending specimen to El Paso is not practical	1	4
Considering the overcrowdedness, I guess we can't complain.	1	4

TOTAL RESPONDENTS: 28

Exhibit S14

SERVICES SATISFACTION/DISSATISFACTION

Socorro

RURAL

Satisfied:	F	%
No Responses		
Dissatisfied:		
There is too much time wasted waiting to be seen by doctors or getting an appointment with a dentist. A life could be lost before medical service is obtained	2	40
Overcrowded offices	1	20
Except for the chiropractor	1	20
Doctors are in too much of a hurry	1	20

TOTAL RESPONDENTS: 5

URBAN

Satisfied:		
All our needs are taken care of	2	29
Our doctor makes house calls	1	14
We have obtained care of our medical problems without much trouble	1	14
I don't get sick much	1	14
Dissatisfied:		
Need more doctors and better facilities. We need specialists in this area	2	29
They don't get around to curing you right away, you have to keep coming back	1	14
One has to go to Socorro even for the services of a midwife. The U.P.H.S. nurse can't do us much good	1	14

TOTAL RESPONDENTS:* 7

*Total includes multiple responses

SERVICES SATISFACTION/DISSATISFACTION

Truth or Consequences

RURAL

Satisfied:	F	%
I don't get sick very often	1	20
Dissatisfied:		
Too much of a hurry and doctors sometimes don't even examine. They direct the nurse to give shots without establishing diagnosis	2	40
They just want your money, but don't do much for you. I'd rather take care of myself at home	1	20
They do not arrive at a diagnosis the first time; patient has to keep coming back	1	20

TOTAL RESPONDENTS: 5

URBAN

Satisfied:		
Except for my arthritis I visit doctors infrequently	1	25
Dissatisfied:		
Service too slow	1	25
Doctors don't spend enough time with patients	1	25
Too much confusion, but things should change now. A new nun is in charge and she really makes them hop at hospital	1	25

TOTAL RESPONDENTS: 4

SERVICES SATISFACTION/DISSATISFACTION

Tucson

RURAL

Satisfied:	F	%
Tucson has good facilities. We don't mess around these facilities	1	33
We seldom are sick, but when there is need, we go to Tucson	1	33
Dissatisfied:		
Services too far apart	1	33

TOTAL RESPONDENTS: 3

Exhibit S17

SERVICES SATISFACTION/DISSATISFACTION

White Sands

URBAN

Satisfied:	F	%
I don't have much trouble because I'm seldom sick	1	33
We've been treated OK so far	1	33
Dissatisfied:		
There is discrimination against retired military people. Have to wait too long for attention	1	33

TOTAL RESPONDENTS: 3

SERVICES SATISFACTION/DISSATISFACTION

Other Locations *

RURAL

Satisfied:	F	%
All my needs are taken care of . Our doctor takes good care of us when we go	6	19
We have no complaints	3	10
This doctor has been our doctor for thirty years	2	7
We have had this doctor in Artesia many years. We have seen this doctor for a few years, and we are satisfied	2	7
The doctor in Alamo seems to take interet	1	3
We never get very sick and when we go, it's OK	1	3
The services I have received have not given me any problems	1	3
They have gotten well when I take them	1	3
They are very polite	1	3
They do their best	1	3
They are sympathetic at times	1	3
Very satisfied	1	3
I never get sick except on rare occasions	1	3
The doctors at the Base are excellent	1	3
We are very satisfied with the doctors in Artesia	1	3
We hardly ever need to go, but they help when we need them	1	3
This doctor knows my whole body system, so he knows what to do for me	1	3
Dissatisfied:		
Not enough doctors	1	3
If only he had a more convenient schedule	1	3
The individual rubs me the wrong way	1	3
They are OK, nothing great	1	3
Very dissatisfied	1	3
There is no doctor that can take care of my illness, so I have to go to Portales which is expensive	1	3
We should have a surgeon closer than El Paso for serious cases	1	3

TOTAL RESPONDENTS:**31

*Locations outside of Southwestern consortium
**Totals include multiple responses

Exhibit S18

Other Locations
(Continued)

URBAN

Satisfied:	F	%
They seem to do their best	3	19
The base doctors have always been good	2	11
The doctors at the base are excellent	1	5
No kicks about it	1	5
It is there whenever needed and I get good competent care		
It is complete. You can get whatever you need in medical attention	1	5
I was very satisfied with Dr. Klump before he died. He was our doctor. We have not been able to find a substitute	1	5
They are very thorough; they usually come out with a diagnosis	1	5
Very satisfied cause it worked	1	5
My mother advises me when I don't feel good	1	5
We are in good shape	1	5
My condition requires treatment and observation in Minnesota, but this climate makes my case more tolerable	1	5
Dissatisfied:		
The doctors do not give you the time and they do not have the right facilities	2	11
As I said, the doctor has a very poor attitude	1	5
I don't like doctors asking questions then getting mad	1	5
We shouldn't have to wait so long for medical attention	1	5

TOTAL RESPONDENTS:* 19

*Totals include multiple responses.

SECTION F

201

Exhibit W_1

Urban and rural population, by counties, New Mexico, 1970

County	1970 Population	Urban Number	Urban Percent	Rural Number	Rural Percent
Catron	2,198	-	-	2,198	100.0
Dona Ana	69,773	46,189	66.2	23,584	33.8
Grant	22,030	10,659	48.4	11,371	51.6
Hidalgo	4,734	3,429	72.4	1,305	27.6
Luna	11,706	8,343	71.3	3,363	28.7
Otero	41,097	33,887	82.5	7,210	17.5
Sierra	7,189	4,656	64.8	2,533	35.2
Socorro	9,763	4,687	48.0	5,076	52.0
Total - 8 County area	168,490	111,850		56,640	
State	1,016,000	708,775	69.8	307,225	30.2

Source: New Mexico's Urban and Rural Population - Agricultural Experiment Station Research Report 207 - September, 1971[39]

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Exhibit W_2

Numbers and percent of the total population of the state in each county, New Mexico, 1970 202

County	Number	Percent
Catron	2,198	0.2
Dona Ana	69,773	6.9
Grant	22,030	2.2
Hidalgo	4,734	0.5
Luna	11,706	1.1
Otero	41,097	4.0
Sierra	7,189	0.7
Socorro	9,763	1.0
Total - 8 County area	168,490	
State	1,016,000	100.0

Source: Changes In The Distribution Of New Mexico's Population Between 1930 And 1970 - Agricultural Experiment Station Research Report 222 - January 1972[38]

Exhibit W_3

Selected characteristics of the population of eight counties

Percentage:	Population Change, April 1970-July 1971	Population Receiving Welfare, March 1972	Population in Food Stamp or Commodity Programs, March 1972	Unemployment, Monthly Average, 1971
Catron	-9.0	4.4	13.2	4.9
Dona Ana	1.0	5.5	15.4	7.6
Grant	1.7	5.5	9.3	6.4
Hidalgo	-0.7	11.2	19.2	3.7
Luna	2.5	8.0	12.0	7.1
Otero	-0.2	3.5	6.5	7.6
Sierra	-1.2	7.1	16.7	4.1
Socorro	0.4	9.9	23.0	10.3

Estimated civilian work force by major racial (and one ethnic) groups
(Averages for first quarter, 1972)

	Civilian Work Force		Employed		Unemployed	
	No.	%	No.	%	No.	%
Total	391,900	100.0	367,600	93.8	24,300	6.2
White*	260,500	100.0	247,600	95.0	12,900	5.0
Spanish Origin or Descent	107,000	100.0	98,300	91.9	8,700	8.1
Indian	15,700	100.0	13,700	87.3	2,000	12.7
Negro	6,300	100.0	5,700	90.5	600	9.5

*Except those of Spanish origin or descent.
Note: Standard U. S. Department of Labor definitions for "employed" and "unemployed".

Source: Bureau of Business Research, ISRAD, The University of New Mexico - 1972

Exhibit W4

Population change, by counties, New Mexico, 1960-1970

County	1960 Population	1970 Population	Change, 1960 to 1970 Number	Percent
Catron	2,773	2,198	-575	-20.7
Dona Ana	59,948	69,773	9,825	16.4
Grant	18,700	22,030	3,330	17.8
Hidalgo	4,962	4,734	-227	-4.6
Luna	9,839	11,706	1,867	19.0
Otero	36,976	41,097	4,121	11.1
Sierra	6,409	7,189	780	12.2
Socorro	10,168	9,763	-405	-4.0
Total - 8 County area	149,775	168,490		
State	951,023	1,016,000	64,977	6.8

Source: Population Changes In New Mexico - Agricultural Experiment Station Research Report 191 - June 1971 37

Exhibit W-2

New Mexico's 1970 land area and population density in 1970

County	Land area in square miles	Persons per square mile
Catron	6,897	0.3
Dona Ana	3,804	18.3
Grant	3,970	5.5
Hidalgo	3,447	1.4
Luna	2,957	4.0
Otero	6,638	6.2
Sierra	4,166	2.7
Socorro	6,603	3.5
Total - 8 County area	38,482	
State	121,412	8.4

Source: Changes In The Distribution Of New Mexico's Population Between 1930 And 1970 - Agriculture Experiment Station Research Report 222 - January 1972

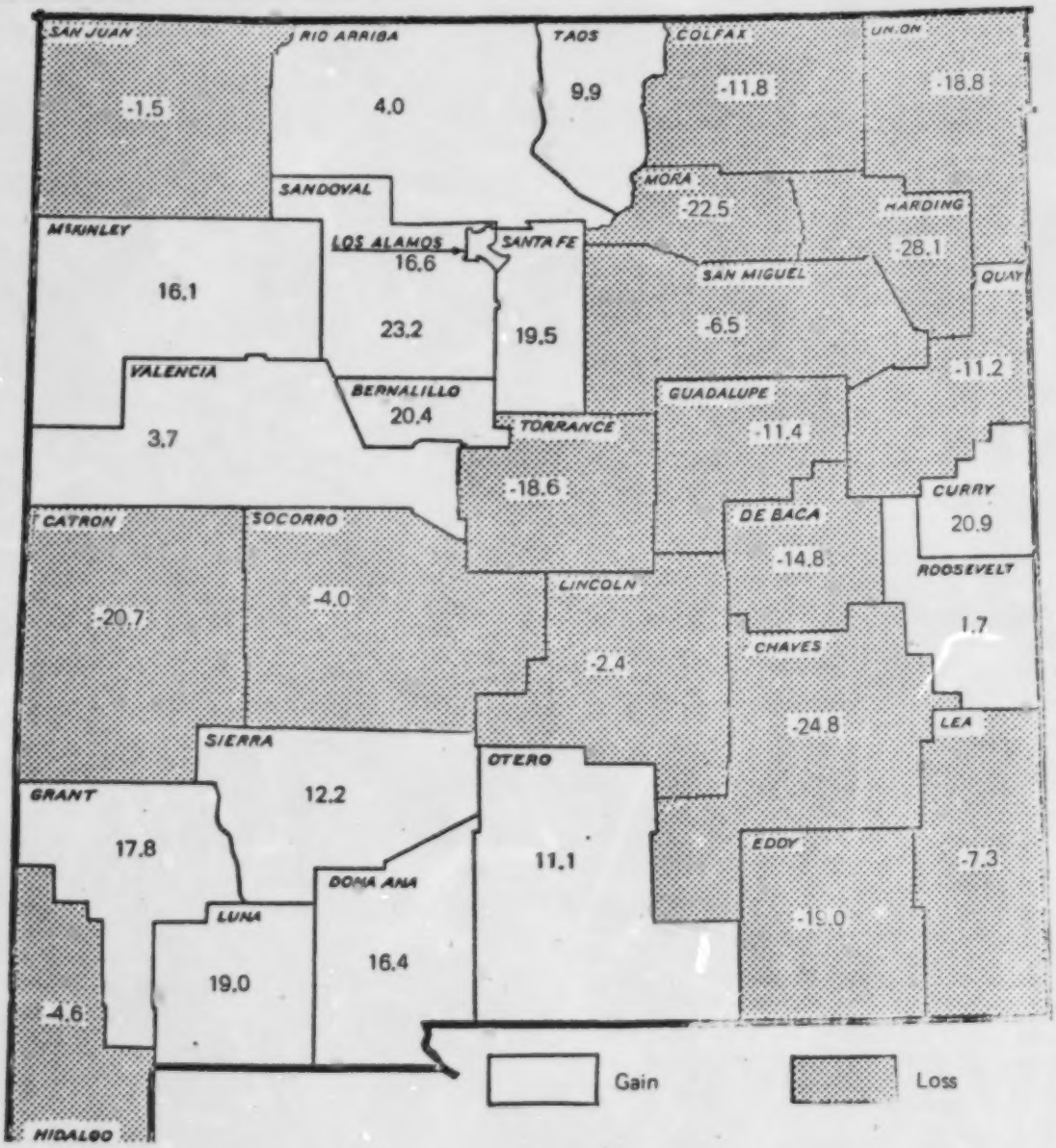
Exhibit W

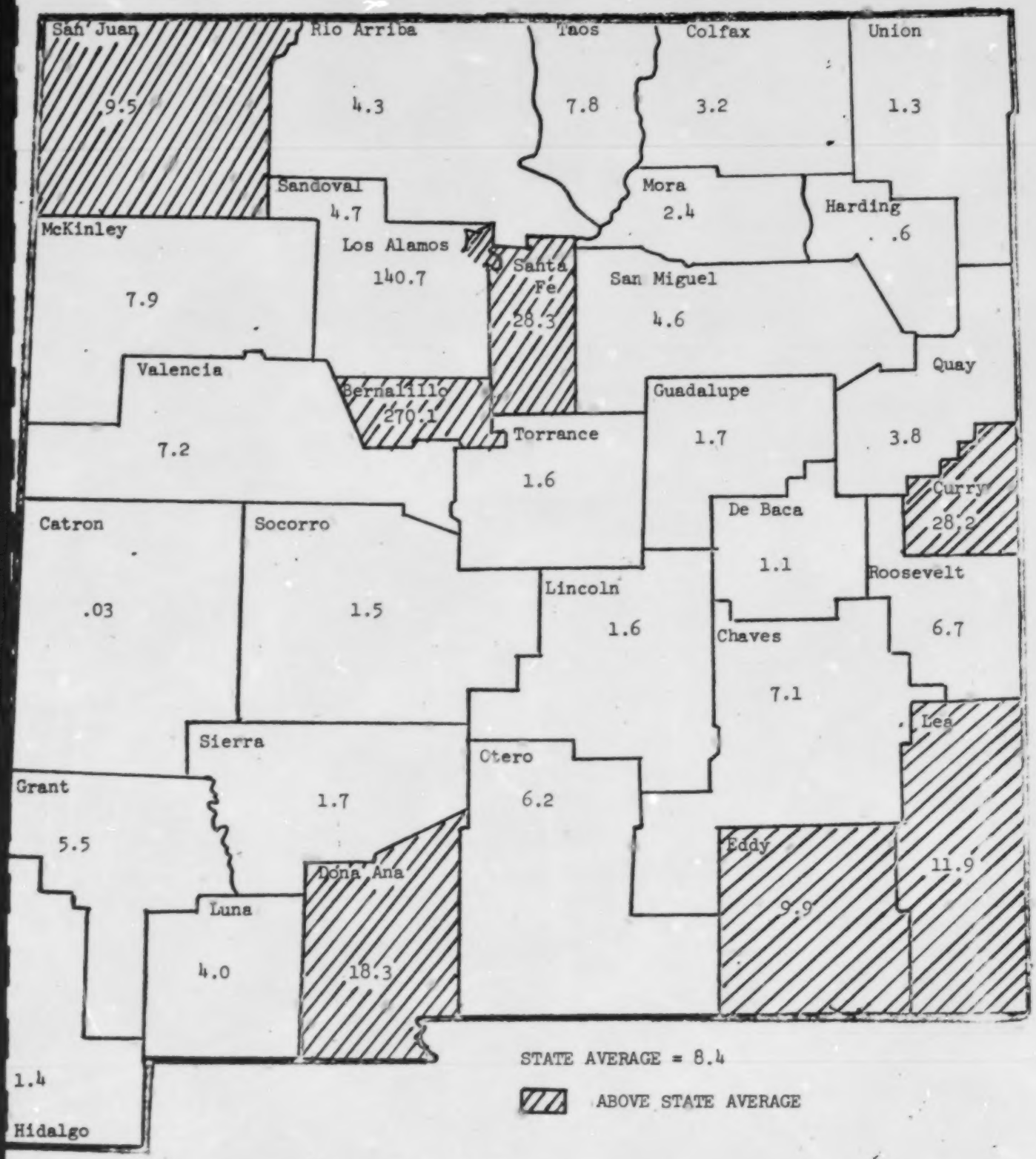
Population of incorporated places, New Mexico, 1970

County	2,500 or more inhabitants	1,000 to 2,499 inhabitants	Less than 1,000 inhabitants
Catron	-		
Dona Ana			
Las Cruces	37,857		
University Park-Tortugas	4,365		
White Sands	4,167		
Anthony		1,723	
La Mesilla		1,733	
Meadow Vista		1,402	
Hatch			867
Grant			
Bayard	2,908		
Silver City	7,751		
Central		1,864	
Hurley		1,795	
Hidalgo			
Lordsburg	3,429		
Virden			151
Luna			
Deming	8,343		
Columbus			241
Otero			
Alamogordo	23,035		
Holloman	8,002		
Tularosa	2,853		
Cloudcroft			525
Sierra			
Truth or Consequences	4,656		
Williamsburg			367
Socorro			
Socorro	4,607		
Magdalena			652
Total - 8 County area	111,850	8,593	2,803

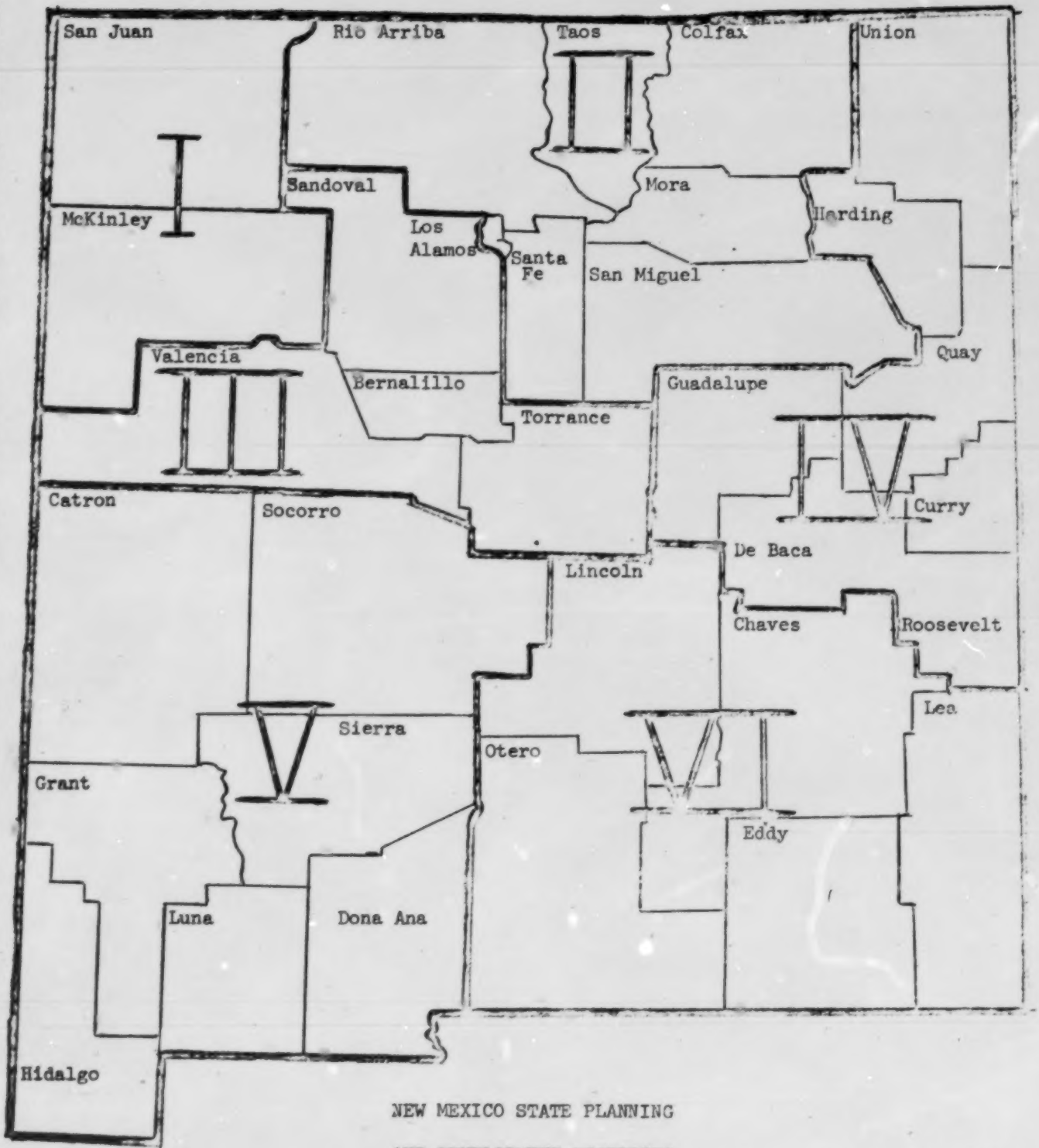
Source: New Mexico's Urban And Rural Population - Agricultural Experiment Station Research Report 207 - September 1971.

Percentage change in the total population, by counties, 1960 to 1970





POPULATION DENSITY PER SQUARE MILE IN NEW MEXICO



NEW MEXICO STATE PLANNING

AND DEVELOPMENT DISTRICTS

SECTION C

CHESS Interviewer Questionnaire Item Guide

INTERVIEWERS PLEASE NOTE:

1. Complete items A–F before starting the interview.
2. Have only the head of household or other adult member (over 25 years of age) answer the questions.

   The HEAD OF THE HOUSEHOLD is that member of the household who makes most major decisions.
3. DO NOT SKIP any question. Ask respondents to answer each question.
4. SOME questions refer only to the head of household while others refer to all members of the household as a unit.
5. On the questionnaire, WRITE respondent answers to the questions accurately and completely, while interviewing. Use the respondent's EXACT WORDS.

Item Numbers:

A. Your interviewer number.

B. Do not fill in.

C. County:

1. Catron
2. Dona Ana
3. Grant
4. Hidalgo
5. Luna
6. Otero
7. Sierra
8. Socorro
9. El Paso

D. Nearest Population Health Center/services: (Refer to your map!)

1. Alamogordo
2. Carrizozo
3. Deming
4. Las Cruces
5. Lordsburg
6. Mescalero
7. Ruidoso
8. Silver City
9. Socorro
10. Truth or Consequences
11. White Sands

E. Distance to nearest Population Health Center/services: (Refer to your map

1. Resident
2. Within 5 miles
3. 6-10 miles
4. 11-20 miles
5. 21-30 miles
6. 31-40 miles
7. 41-50 miles
8. over 50 miles

F. Residence location: Population Center or Population Center Suburbs

Resident:

1. Alamogordo
2. Carrizozo
3. Deming
4. Las Cruces
5. Lordsburg
6. Mescalero
7. Ruidoso
8. Silver City
9. Socorro
10. Truth or Consequences
11. White Sands
12. Population centers of more than 75 people but not listed in 1-11.

Rural Resident:

13. Open rural, farms, ranches
14. Less than 75 people in a small village or cluster of residences separated by an equivalent distance of not more than 6 average city blocks.

SOUTHERN NEW MEXICO HEALTH/MEDICAL CARE SURVEY

CHESS
NMSU See interviewer instructions for items A–F:

A. Interviewer No. B. Interview Control No. C. County

1-6 _____ _____ _____ _____ _____ _____

D. Nearest population Health Center/Services

7-8 _____ _____

E. Distance to nearest large population Health Center/Services

9 _____

F. Residence location

10-11 _____ _____

PLEASE ANSWER THE FOLLOWING HEALTH/MEDICAL CARE QUESTIONS AS THEY PERTAIN TO YOU OR YOUR HOUSEHOLD. WE DO NOT ASK YOUR NAME. WE ASK ONLY FOR YOUR OPINION AND A FEW MINUTES OF YOUR TIME. THERE ARE NO RIGHT OR WRONG ANSWERS. WE NEED TO KNOW YOUR OPINIONS TO ASSIST SOURCES IN PLANNING AND PROVIDING FOR YOUR HOUSEHOLD.S HEALTH/ MEDICAL CARE NEEDS.

HEALTH CARE LOCATION:

Where do you and the other members of your household most frequently go for health/ medical care? (CHECK ONE ONLY)

A. NEAREST large Population Center (1) — or — B. Major Health Center (2) (If not nearest large population center)

13 ___ 14-15 ___ ___

_____ 1. Alamogordo
_____ 2. Carrizozo
_____ 3. Deming
_____ 4. Las Cruces
_____ 5. Lordsburg
_____ 6. Mescalero
_____ 7. Ruidoso
_____ 8. Silver City
_____ 9. Socorro
_____ 10. Truth or Consequences
_____ 11. White Sands

_____ 12. Albuquerque
_____ 13. Belen
_____ 14. El Paso
_____ 15. Tucson
_____ 16. Phoenix
_____ 17. Safford/Springerville
_____ 18. Other (Specify) _____

FINANCIAL HEALTH PROTECTION:

Currently, is the head of your household financially covered for extended illness by any of the following protective health programs/personal resources? (CHECK ALL THAT APPLY)

16 ____ 1. Personal economic resources
17 ____ 2. Guaranteed financial assistance from relatives or friends
18 ____ 3. Private insurance
19 ____ 4. Group insurance (work)
20 ____ 5. Medicare/Medicaid
21 ____ 6. Employees disability insurance
22 ____ 7. Religious/brotherhood support
23 ____ 8. No
24 ____ 9. Don't Know

HOUSEHOLD HEALTH ASSESSMENT:

General household health level: (CHECK ONE ONLY)

____ 1. Excellent, rare sickness
____ 2. Good, some sickness but infrequent
25 ____ 3. Fair, some sickness alternating with good health
____ 4. Poor, continuous or frequent sickness of some type

Does any member of your household have a special/recurrent health problem?

26 ____ 1. Yes ____ 2. No

If yes to question number 4, please name the recurrent health problem(s).

27-28 __ __ _____

What needs to be provided for your household to facilitate care of this special health care problem? (Specify) _____

29-30 __ __ _____

What is needed to help rehabilitate the member(s) of your household with recurrent health problem(s)? (Probe) _____

31-32 __ __ _____

_____

RESIDENT HEALTH IMAGE AND HEALTH PROCESS:

What are the three most important symptoms you use in determining when a household member is ill?

33 __ 1. _____

34 __ 2. _____

35 __ 3. _____

(Interviewers probe):

Physical irregularities
Psychological changes
Sociological changes

Please try to recall situations of personal illness, or the illnesses of other members of your household in the past few years.

Listed below are some of the various stages in the illness process. Also listed are some alternative sources of influence that might or might not be important influences in each illness stage. Note that the order of these stages is arbitrary and may vary according to the nature of illness and individual circumstances.

Assume a rather serious illness affects you or a household member.

What is the most important source that most frequently influences your action decisions at each particular stage of the illness process? (Select from the following list):

1. Myself
2. Physician (family or specialist)
3. Chiropractor
4. Curandero
5. Herbero
6. Dentist
7. Optometrist, ophthamologist
8. Nurse (including school and public health)
9. Friends
10. Relatives
11. Pharmacist-Druggist
12. Paraprofessional
13. Self treatment, medication
14. Other (Specify) _____
15. Priest
16. Black Magic

A. Determination of illness

36, 37 __ __ 1. _____

B. Discussing the illness and possible causes

38, 39 __ __ 1. _____

(Continued) What are the two most important sources that most frequently influence your action decisions at each particular stage of the illness process? (Select from the following list):

1. Myself
2. Physician (family or specialist)
3. Chiropractor
4. Curandero
5. Herbero
6. Dentist
7. Optometrist, ophthamologist
8. Nurse (including school and public health)
9. Friends
10. Relatives
11. Pharmacist-Druggist
12. Paraprofessional
13. Self treatment, medication
14. Other (Specify) _____
15. Priest
16. Black Magic

C. Who do you see first in determining what's wrong? (establishing diagnosis)

40, 41 __ __ 1. _____

D. Accepting the fact of illness

42, 43 __ __ 1. _____

E. Who do you see first for treatment (if different from diagnosis?)

44 45 __ __ 1. _____

F. Following prescribed treatment recommendations

46, 47 __ __ 1. _____

G. Discontinuance of activities

48, 49 __ __ 1. _____

H. Deciding recovery

50, 51 __ __ 1. _____

HEALTH MANPOWER:

Where do your household members go for health services? (CHECK ALL THAT APPLY).

		Used last 5 years? 1. yes 2. no	If not used did you need one? 1. yes 2. no	If not needed nor used, at least did you know about? 1. yes 2. no	Evaluation 1. Excellent 2. Good 3. Fair 4. Poor 5. Don't Know	Recommended Changes for Enhancing Use (Probe)
52-55	M.D. Family Doctor (G.P.)					
56-59	M.D. Specialist					
60-63	Osteopath					
64-67	Chiropractor					
68-71	Naturopath					
72-75	Midwife					
76-79	Astrologer					
80[1]						
5-8	Faith healer (Christian Science Practitioner)					
9-12	Yerbero					
13-16	Curandero					
17-20	Dentist					
21-24	Optometrist					
25-28	Opthalmologist (M.D. eye doctor)					
29-32	Druggist (Pharmacist)					
33-36	Nurse (including school and public health)					
37-40	Physicians assistant/ paraprofessional					
41-44	Black Magic					

Other (Specify) _____

HEALTH SERVICE FACILITIES:

Which health service facilities do you and the other members of your household use? (CHECK ALL THAT APPLY)

		Used last 5 years 1. yes 2. no	If not used did you need one? 1. yes 2. no	If not needed nor used, at least did you know about? 1. yes 2. no	Evaluation 1. Excellent 2. Good 3. Fair 4. Poor 5. Don't Know	Recommended Changes for Enhancing Use (Probe)
45-48	City, County, Community hospital					
49-52	Private and/or religious hospital					
53-56	Bureau of Indian Affairs or United States Public Health Service Clinic					
57-60	Neighborhood or population center health clinic					
61-64	Nursing home, home for the aged					
65-68	Sanatorium					
69-72	Mobile unit (diagnostic and/or treatment					
73-76	Ambulance					
80 2						
5-8	School nurses office or clinic					
9-12	Military hospital/facilities or Veteran's Administration facilities					
13-16	Drugstore					
17-20	Our home					
21-24	Physician, dentist, etc. office					
25-28	Hospital emergency room					
29-32	Special migrant worker facilities					

CONDITIONS FOR HEALTH SERVICES USE:

For what reason(s) do you and the other members of your household use health services? (CHECK ALL THAT APPLY)

		Used last 5 years 1. yes 2. no	If not used did you need to use? 1. yes 2. no	If not needed nor used, at least did you know about services? 1. yes 2. no	Evaluation 1. Excellent 2. Good 3. Fair 4. Poor 5. Don't Know	Recommended changes for Enhancing Use (Probe)
33-36	Accidents/broken bones					
37-40	Burns					
41-44	Infectious diseases (measles, mumps)					
45-48	Minor surgery (cyst and wart removal)					
49-52	Major surgery (hysterectomy)					
53-56	Respiratory (T.B., emphysema, pneumonia)					
57-60	Cancer and terminal illness					
61-64	Out-patient laboratory work (blood sample, urinalysis					
65-68	Family Planning Services (Birth control)					
69-72	Chiropractic adjustments					
73-76	Mental/emotional/drugs/ alcohol					
80 3						
5-8	Toothache/tooth repair					
9-12	False teeth					
13-16	Colds and/or flu virus					
17-20	"Susto"					
21-24	Glasses, contact lenses					
25-28	Eye surgery, cataracts					

DIAGNOSTIC/PREVENTATIVE HEALTH SERVICES:

Which diagnostic/preventative health services do you and the other members of your household use? (CHECK ALL THAT APPLY)

		Used last 5 years 1. yes 2. no	If not used did you need to use? 1. yes 2. no	If not needed nor used, at least did you know about? 1. yes 2. no	Evaluation 1. Excellent 2. Good 3. Fair 4. Poor 5. Don't Know	Recommended changes for Enhancing Use (Probe)
29-32	Vaccination, innoculation					
33-36	Sex education and veneral disease prevention					
37-40	Nutrition and foods					
41-44	Diagnostic (T.B. X-ray, T.B. patch, pap smear, diabetic urinalysis detection)					
45-48	Annual or regular physical examination					

PREGNANCY, PRENATAL, AND POSTNATAL HEALTH SERVICES:

Have any of your household members used pregnancy, prenatal, and postnatal services in the last 5 years? (CHECK ALL THAT APPLY)

		Used last 5 years 1. yes 2. no	If not used did you need to use? 1. yes 2. no	If not needed nor used, at least did you know about? 1. yes 2. no	Evaluation 1. Excellent 2. Good 3. Fair 4. Poor 5. Don't Know	Recommended changes for Enhancing Use (Probe)
49-52	Prenatal services					
53-56	Delivery					
57-60	Postnatal, pediatric, and child health care					

9

HEALTH EDUCATION AND TRAINING:

Is your household satisfied with the health services/care you receive? (CHECK ONE ONLY).

61
_____ 1. Very satisfied
_____ 2. Partially satisfied
_____ 3. Partially dissatisfied
_____ 4. Very dissatisfied

A. Why or why not? _____

Assume that you or a member(s) of your household were interested in learning more about the subject(s) of health/medical care.

Now considering your practical household situation, what way(s) do you prefer to learn more about health/medical care? (CHECK ALL THAT APPLY)

62 _____ 1. Adult education courses
63 _____ 2. Lectures and discussions with people
64 _____ 3. Newspapers and magazines
65 _____ 4. Special literature and pamphlets
66 _____ 5. Television and radio
67 _____ 6. Educational movies
68 _____ 7. Talks with friends or relatives
69 _____ 8. Contact at home by voluntary or public health organization workers
70 _____ 9. Mobile educational van
71 _____ 10. Other (Specify) _____

80 4

What topics should be included in your learning/training? (CHECK ALL THAT APPLY)

5 _____ 1. General household health care
6 _____ 2. Follow-up care after illness
7 _____ 3. Pre-natal care
8 _____ 4. Infant and child care
9 _____ 5. Understanding and rehabilitation for military veterans
10 _____ 6. Homemaker, home nursing skills
11 _____ 7. Services for the handicapped (including speech and hearing impairments)
12 _____ 8. Health problems for migrant workers
13 _____ 9. Family planning (birth control)
14 _____ 10. Dental hygiene
15 _____ 11. Health care for elderly people
16 _____ 12. Nutrition (meal planning, diets)
17 _____ 13. Sanitation household practices (garbage, waste disposal)
18 _____ 14. Emergency first aid
19 _____ 15. Disaster training (floods, fires, tornados, etc.)
20 _____ 16. Other _____
_____ 17. Animal control and health
_____ 18. Insect control

A. Do you think more health education/training is needed for the members of this household?

21
_____ 1. yes
_____ 2. No

DEMOGRAPHIC INFORMATION:

Are you the head of your household?

22 ____ 1. Yes ____ 2. No

23-24 If no, how old is the head of your household? _____ years

25-26 How old are you? _____ years

What is your relation to the head of household?

27__ ____ 1. Same ____ 4. Spouse
____ 2. Son ____ 5. Other relative
____ 3. Daughter ____ 6. Other

What is your sex?

28 ____ 1. Male ____ 2. Female

How long have you lived:

29-30 In this state _____ years.
31-32 In this county _____ years.
33-34 At this address _____ years.

How many people, including yourself, are living in your household?

35-36 _____ number of people

Which of the following income categories is your family in (total household income before tax deductions, insurance, etc.; please include the income of all members of the household from all sources such as wages, pensions, welfare, etc.):

37 ____ 1. Under $1000 year ____ 5. $9000 - $12,000
____ 2. $1001 - $3000 ____ 6. $12,001 - $15,000
____ 3. $3001 - $5999 ____ 7. $15,001 - $20,000
____ 4. $6000 - $8999 ____ 8. over $20,000

What is your household mailing address? (optional)

_____ _____
Street or Box Number Zip Code

What is the head of the household's religion?

38
____ 1. None
____ 2. Catholic
____ 3. Protestant
____ 4. Other _____

From what ethnic group is the head of the household?

39
____ 1. Spanish-American, Mexican-American
____ 2. Indian
____ 3. Black
____ 4. Anglo
____ 5. Other _____

40-41 What is the highest grade in school completed by the head of your household? _____

What is the occupation of the head of the household? Please specify (for example, telephone lineman rather than works for the telephone company). _____

42-43 _____

Is the head of household:

44
____ 1. Self employed
____ 2. Works for the government (federal, state, or local)
____ 3. Is in the military
____ 4. Works for a private company
____ 5. Is retired
____ 6. Other (specify) _____

45 Does the head of the household have a driver's license? ____ 1. Yes ____ 2. No

46 Does the head of the household have an automobile? ____ 1. Yes ____ 2. No

Where you live, the members of your household have access to:

47
____ 1. All weather roads always accessible within ¼ mile
____ 2. Secondary roads passable most of the time
____ 3. Seasonal non-passable roads
____ 4. Other _____

80 5 ADDITIONAL COMMENTS: _____

THANK YOU

CHESS Interviewer Questionnaire Item Guide

INTERVIEWERS PLEASE NOTE:

1. Complete items A–F before starting the interview.
2. Have only the head of household or other adult member (over 25 years of age) answer the questions.

   The HEAD OF THE HOUSEHOLD is that member of the household who makes most major decisions.
3. DO NOT SKIP any question. Ask respondents to answer each question.
4. SOME questions refer only to the head of household while others refer to all members of the household as a unit.
5. On the questionnaire, WRITE respondent answers to the questions accurately and completely, while interviewing. Use the respondent's EXACT WORDS.

Item Numbers:

A. Your interviewer number.

B. Do not fill in.

C. County:

1. Catron
2. Dona Ana
3. Grant
4. Hidalgo
5. Luna
6. Otero
7. Sierra
8. Socorro
9. El Paso

D. Nearest Population Health Center/services: (Refer to your map!)

1. Alamogordo
2. Carrizozo
3. Deming
4. Las Cruces
5. Lordsburg
6. Mescalero
7. Ruidoso
8. Silver City
9. Socorro
10. Truth or Consequences
11. White Sands

E. Distance to nearest Population Health Center/services: (Refer to your map!

1. Resident
2. Within 5 miles
3. 6-10 miles
4. 11-20 miles
5. 21-30 miles
6. 31-40 miles
7. 41-50 miles
8. over 50 miles

F. Residence location: Population Center or Population Center Suburbs

Resident:

1. Alamogordo
2. Carrizozo
3. Deming
4. Las Cruces
5. Lordsburg
6. Mescalero
7. Ruidoso
8. Silver City
9. Socorro
10. Truth or Consequences
11. White Sands
12. Population centers of more than 75 people but not listed in 1-11.

Rural Resident:

13. Open rural, farms, ranches
14. Less than 75 people in a small village or cluster of residences separated by an equivalent distance of not more than 6 average city blocks.

SOUTHERN NEW MEXICO HEALTH/MEDICAL CARE SURVEY

CHESS
NMSU See interviewer instructions for items A-F:

A. Interviewer No. B. Interview Control No. C. County

I-6 _____ _____ ____ _____ ____ ____

D. Nearest population Health Center/Services

7-8 _____ _____

E. Distance to nearest large population Health Center/Services

9 _____ _____

F. Residence location

10-11 _____

POR FAVOR CONTESTE LAS SIGUIENTES PREGUNTAS SOBRE LA ATENCIÓN MÉDICA Y DE SALUD COMO LE PERTENEZCAN A USTED O A SU FAMILIA. NO LE PEDIMOS SU NOMBRE, SOLAMENTE PEDIMOS SU OPINIÓN Y UNOS CUANTOS MINUTOS DE SU TIEMPO. NO HAY RESPUESTAS QUE SÉAN CORRECTAS O INCORRECTAS. NECESITAMOS SABER SU PARECER CON EL FIN DE AYUDAR A ALGUNOS QUE SE INTERESAN EN PLANEAR Y A SURTIRLE SUS MENESTERES DE SALUD Y ATENCIÓN MÉDICA PARA SU FAMILIA.

SITIO DE ATENCIÓN DE SANIDAD:

¿A donde van con más frecuencia usted y los otros miembros de su casa a obtener atención médica y de la salud? (MARQUE SOLAMENTE UNA)

A. El centro MÁS CERCANO con población de gran magnitud (1)

B. Centro principal de sanidad (si es que no esta cerca de un centro de gran población)

13 ___

14-15 ___ ___

- ____ 1. Alamogordo
- ____ 2. Carrizozo
- ____ 3. Deming
- ____ 4. Las Cruces
- ____ 5. Lordsburg
- ____ 6. Mescalero
- ____ 7. Ruidoso
- ____ 8. Silver City
- ____ 9. Socorro
- ____ 10. Truth or Consequences
- ____ 11. White Sands
- ____ 12. Albuquerque
- ____ 13. Belén
- ____ 14. El Paso
- ____ 15. Tucsón
- ____ 16. Phoenix
- ____ 17. Safford/Springerville
- ____ 18. Otro(Especifique_____

PROTECCIÓN FINANCIERA DE SALUD

2

¿ Está el principal de su familia corrientemente protegido contra una enfermedad prolongada por alguna de los siguientes programas protectores de salud o por recursos personales? (MARQUE TODOS LOS QUE SÉAN APLICABLES)

16 ____ 1. Recursos económicos personales
17 ____ 2. Ayuda financiera garantizada de parientes o amistades
18 ____ 3. Seguro particular
19 ____ 4. Seguro de trabajo (para grupos)
20 ____ 5. Ayuda médica federal (Medicare/Medicaid)
21 ____ 6. Seguro para empleados incapacitados
22 ____ 7. Sostén religioso o de fraternidad
23 ____ 8. No
24 ____ 9. No sé

AVALÚO DE LA SALUD DE LA FAMILIA

Nivel general de la salud de la familia (MARQUE SOLAMENTE UNA)

____ 1. Excelente, rara vez hay enfermedad
____ 2. Bueno, algunas enfermedades pero sin frequencia
25 ____ 3. Regular, una que otra enfermedad alternante con la buena salud
____ 4. En mal estado, enfermedades continuas y con frecuencia, de un tipo u otro.

¿ Hay algún miembro de su familia que tenga algún problema de salud que séa especial o recurrente?

26 _____ 1. Sí _____ 2. No

Si contesto sí a la pregunta número 4, favor de nombrar el problema de salud recurrente.

27-28 __ __ _____

¿ Qué hay que proveer a su familia para facilitar la atención a este problema especial de atención de sanidad? (ESPECIFIQUE) _____

29-30 __ __ _____

¿ Qué se necesita para ayudar a rehabilitar al miembro (o miembros) de su familia con problema (o problemas) de sanidad recurrente (s)? (INDAGUE)

31-32 __ __ _____

_____

_____

RESIDENT HEALTH IMAGE AND HEALTH PROCESS: 3

¿ Cúales son los síntomas más importantes que usted utiliza para decidir que algún miembro de la familia está enfermo?

33____ 1. _____

34____ 2. _____

35____ 3. _____

(Interviewers probe):

Physical irregularities
Psychological changes
Sociological changes

Por favor trate de recordar alguna ocasión en que usted haya tenido alguna enfermedad personalmente, o de enfermedades de los otros miembros de su familia en los últimos años.

Puestos en lista abajo están algunas de las varias etapas en el procedimiento de la enfermedad. También en lista están algunas fuentes alternativas de influjo que podrán ser o no ser un gran influjo en cada etapa de la enfermedad. Fíjese que el orden en que aparecen estas etapas es arbitrario y pueden variar según la clase de enfermedad y las circunstancias particulares.

Suponga que una enfermedad bastante seria le está afectando a usted o a un miembro de su familia.

¿ Cuales son dos de las fuentes de más importancia que lo influyen con más frecuencia en su determinación de como proceder en cada etapa del procedimiento de la enfermedad? (ESCOJA DE LA LISTA SIGUIENTE):

1. Yo mismo
2. El médico (de la familia o especialista)
3. El quiropráctico (sobador)
4. El curandero
5. Yerbero
6. El dentista
7. El optómetra, oftalmólogo
8. La enfermera (inclusive la escolar y de salubridad pública)
9. Amistades
10. Parientes
11. Farmacéutico-boticario
12. Asistenta del profesional con licencia
13. Dar tratamiento o medicamento a si mismo.
14. Otro (Especifique _____ _____
15. El padre
16. Brujo (a)

A. Definición de la enfermedad

36 1. _____

37 2. _____

- Cual es la fuente de mas importancia que lo influyen con mas frecuencia en su determinacion de como proceder en cada etapa del procedimiento de la enfermedad? (ESCOJA DE LA LISTA SIGUIENTE):

1. Yo mismo
2. El Medico (de la familia o especialista)
3. El quiropractico (sobador)
4. El curandero
5. Yerbero
6. El dentista
7. El optometra, oftalmologo
8. La enfermera (inclusive la escolar y de salubridad publica)
9. Amistades
10. Parientes
11. Farmaceutico-boticario
12. Asistente del profesional con licencia
13. Dar tratamiento o medicamento a si mismo.
14. Otro (Especifique _____ _____
15. El padre
16. Brujo (a)

38, 39 B. Discusion de la enfermedad y de sus causas posibles.
I. _____

40, 41 C. A quien ve primeramente para determinar el mal? (establecer el diagnostico)
I. _____

42, 43 D. Reconocer la realidad de la enfermedad
I. _____

44, 45 E. A quien ve primeramente para el tratamiento (si es diferente a lo del (diagnostico)?
I. _____

46, 47 F. Poner atencion a las recomendaciones para el tratamiento recetado.
I. _____

48, 49 G. Suspension de actividades
I. _____

50, 51 H. Decision de la recuperacion.
I. _____

RESIDENT HEALTH IMAGE AND HEALTH PROCESS:

Cuales son los sintomas mas importantes que usted utiliza para decidir que algun miembro de la familia esta enfermo?

33 ___ I._____

34 ___ 2._____

35___ 3._____

(Interviewers probe):

Physical irregularities

Psychological changes

Sociological changes

Por favor trate de recordar alguna ocasion en que usted haya tenido alguna enfermedad personalmente, o de enfermedades de los otros miembros de su familia en los ultimos anos.

Puestos en lista abajo estan algunas de las varias etapas en el procedimiento de la enfermedad. Tambien en lista estan algunas fuentes alternativas de influjo que podran ser o no ser un gran influjo en cada etapa de la enfermedad. Fijese que el orden en que aparecen estas etapas es arbitrario y pueden variar segun la clase de enfermedad y las circunstancias particulares.

Suponga que una enfermedad bastante seria le esta afectando a usted o a un miembro de su familia.

Cual es la fuente de mas importancia que lo influyen con mas frecuencia en su determinacion de como proceder en cada etapa del procedimiento de la enfermedad? (ESCOJA DE LA LISTA SIGUIENTE):

1. Yo mismo
2. El medico (de la familia o especialista)
3. El quiropractico (sobador)
4. El curandero
5. Yerbero
6. El dentista
7. El optometra, oftalmologo
8. La enfermera (inclusive la escolar y de salubridad publica)
9. Amistades
10. Parientes
11. Farmaceutico-boticario
12. Asistente del profesional con licencia
13. Dar tratamiento o medicamento a si mismo.
14. Otro (Especifique _____ _____
15. El padre
16. Brujo (a)

36,37 A. Definicion de la enfermedad 259

I. _____

5

POTENCIAL HUMANA DE SANIDAD

¿ A donde acuden los miembros de su familia para los auxilios de sanidad? (MARQUE TODOS LOS QUE APLIQUEN)

		utilizado los últimos 5 años? 1. Sí 2. No	Si no los utilizó tuvo necesidad de alguno 1. Sí 2. No	Si no los usó ni hubo necesidad al menos de ellos? 1. Sí 2. No	Avalúo 1. Excelente 2. Bueno 3. Regular 4. Mal 5. No sé	Cambios recomendados para mejor el uso (Probe)
52-55	Médico, de la familia práctica general					
56-59	Médico, especialista					
60-63	Osteópata					
64-67	Quiropráctico					
68-71	Naturopato, Naturópata					
72-75	Partera					
76-79	Astrólogo					
80 1 5-8	Sanador por fe (practicante de la Ciencia Cristiana)					
9-12	Yerbero					
13-16	Curandero					
17-20	Dentista					
21-24	Optómetra					
25-28	Optalmólogo (Médico de los ojos)					
29-32	Farmacéutico (boticario)					
33-36	Enfermera (la escolar, la de salubridad pública)					
37-40	Asistente del médico (paraprofesional)					
41-44	Brujo(a)					

Otro (especifique)

HEALTH SERVICE FACILITIES 6

¿ Cuales facilidades para el servicio de la salud utilizan usted o los otros miembros de su familia? (MARQUE TODOS LOS QUE APLIQUEN)

		utilizado los últimos 5 años 1. Sí 2. No	Si no los utilizó tuvo necesidad de alguno 1. Sí 2. No	Si no los usó ni hubo necesidad al menos de ellos? 1. Sí 2. No	Avalúo 1. Excelente 2. Bueno 3. Regular 4. Mal 5. No se	Cambios recomendados para mejorar el uso (Probe)
45-48	Hospital de cuidad, condado o de la comunidad					
49-52	Hospital privado o religioso					
53-56	Agencia de asuntos indígenos o clínica del servicio de salubridad publica de EEUU					
57-60	Clínica del barrio o de centro de población					
61-64	Sanatorio particular, hospedería para los ancianos					
65-58	Sanatorio para la curación de inválidos con ciertas enfermedades					
69-72	Unidad movil para diagnóstico o tratamiento					
73-76	Ambulancia					
80[2]						
5-8	Clínica o la oficina de la enfermera de escuela					
9-12	Facilidades de hospital militar: o de la administración de veteranos					
13-16	Botica					
17-20	Nuestra casa					
21-24	Consultorio del médico, dentista, etc.					
25-28	Sala de urgencia de hospital					
29-32	Facilidades especiales para obrero migratorio					

CONDITIONS FOR HEALTH SERVICES USE:

¿ Por qué razón o razones utilizan usted o los otros miembros de su familia los servicios de sanidad? (MARQUE TODOS LOS QUE APLIQUEN)

		utilizado los últimos 5 años 1. Sí 2. No	Si no los utilizó tuvo necesidad de usarlos? 1. Sí 2. No	Si no utilizó los servicios ni los necesito, al menos supo usted de ellos? 1. Sí 2. No	Avalúo 1. Excelente 2. Bueno 3. Regular 4. Mal 5. No sé	Cambios recomendados para mejorar el uso
33-36	Accidentes/quebradura de huesos					
37-40	Quemaduras					
41-44	Enfermedades infecciones (sarampión, paperas)					
45-48	Cirugía menor (removimiento de quistes y verrugas)					
49-52	Cirugía mayor (histerectomia)					
53-56	Respiratorio (tuberculosis, enfisema, pulmonía)					
57-60	Cancer y enfermedad terminal					
61-64	Trabajo de laboratorio para pacientes externos (prueba de sangre, analisis de la orina)					
65-68	Servicios para el planeamento de la familia (control de natalidad)					
69-72	Ajustamientos quiropracticos:					
73-76	Mentales/emocional/drogas/el alcohol					
80-3						
5-8	Dolor de diente o de Muela/restauracion dental					
9-12	Dentura postiza					
13-16	Resfríos y/o gripe de virus					
17-20	"Susto"					
21-24	Anteojos, lentes de contacto					
25-28	Cirujía de los ojos, catarata					

DIAGNOSTIC/PREVENTATIVE HEALTH SERVICES: 8

¿ Cuales servicios de sanidad diagnósticos y preventivos utilizan usted y los miembros de su familia? (MARQUE TODOS LOS QUE APLIQUEN)

		utilizado los últimos 5 años 1. Sí 2. No	Si no los utilizó tuvo necesidad de usarlos? 1. Sí 2. No	Si no los utilizó ni los necesitó, al menos sabía Ud. de ellos? 1. Sí 2. No	Avalúo 1. Excelente 2. Bueno 3. Regular 4. Mal 5. No sé	Cambios recomendados para mejorar el uso. (Probe)
29-32	Vacunas, inoculaciones					
33-36	Enseñanza sobre el sexo y la prevención de enfermedades venereas					
37-40	Alimentación y comidas					
41-44	Diagnóstico (radiografía para tuberculosis, parche para tuberculosis, descubrimiento del diabetis, por medio de análisis de la orina					
45-48	Examen físico regular o anual					

EMBARAZOS; SERVICIOS DE SALUD PRENATAL Y POSTNATAL:

Ha utilizado algún miembro de su familia los servicios de sanidad por embarazo, prenatales o postnatales en los últimos 5 años? (MARQUE TODOS LOS QUE APLIQUEN)

		utilizado los últimos 5 años 1. Si 2. No	Si no los utilizó hubo necesidad de utilizarlos? 1. Si 2. No	Si no se utilizaron ni se necesitaron, al menos sabía Ud. de ellos? 1. Si 2. No	Avalúo 1. Excelente 2. Bueno 3. Regular 4. Mal 5. No sé	Cambios recomendados para mejorar el uso. (Probe)
49-52	Servicios prenatales					
53-56	Partos					
57-60	Atención postnatal, pediatrica, o para la salud de los niños					

9

HEALTH EDUCATION AND TRAINING:

¿Está su familia satisfecha con la atención de los servicios de sanidad que recibe? (MARQUE SOLAMENTE UNA)

61
- ____ 1. Muy satisfecha
- ____ 2. Satisfecha en parte
- ____ 3. Disgustada en parte
- ____ 4. Muy disgustada

A. Por que o por que no? _____

Suponga que usted o un miembro (s) de su familia se interesarán en aprender mas sobre el asunto(s) de atención medica y de la salud.

¿Ahora, tomando en cuenta su estado práctico de la familia, de que manera(s) preferiría usted aprender mas sobre la atención médica y de la salud? (MARQUE TODO LO QUE APLIQUE)

62 ____ 1. Cursos de educacion para adultos
63 ____ 2. Conferencias y discusiones con otras gentes
64 ____ 3. Periódicos y revistas
65 ____ 4. Literatura especial y folletos
66 ____ 5. Televisión y radio
67 ____ 6. Películas de enseñanza
68 ____ 7. Pláticas con amistades o parientes
69 ____ 8. Contacto en casa con voluntarios o trabajadores de la organización de salubridad pública.
70 ____ 9. Camión movil de ensenanza
71 ____ 10. Otra (Especifique) _____

80[4] ____

¿Qué tópicos deben ser inclusos en su aprendizaje o entrenamento? (MARQUE TODO LO QUE APLIQUE)

5 ____ 1. Atención general de la salud de la familia
6 ____ 2. Atención continua después de la enfermedad
7 ____ 3. Atención pre-natal
8 ____ 4. Atención infantil y puericultura
9 ____ 5. Comprensión de los veteranos militares y su rehabilitación
10 ____ 6. Destreza en el cuidado de los enfermos en casa por parte de la ama de casa.
11 ____ 7. Servicios para los incapacitados (inclusive impedimentos de oído y de habla)
12 ____ 8. Problemas de la salud para los obreros migratorios
13 ____ 9. Control de natalidad
14 ____ 10. Higiene dental
15 ____ 11. Atención de la salud de los ancianos
16 ____ 12. Alimentación (planear las comidas, dietas
17 ____ 13. Costumbres sanitarios de la familia (desperdicios, el deshacer de los despojos)
18 ____ 14. Primeros auxilios en una urgencia
19 ____ 15. Entrenamento en los desastres (diluvios, quemazones, huracanes)
20 ____ 16. Otro _____
____ 17. Control de animales y su salud
____ 18. Control de insectos

A. ¿Cree usted que hay necesidad de mas enseñanza o entrenemento para los miembros de esta casa?

21 ____ 1. Sí ____ 2. No

10

INFORMACIÓN DEMOGRÁFICA:

¿ Es usted el principal de su familia?

22 _____ 1. Sí _____ 2. No

23-24 Si no es, ¿que edad tiene el principal de su familia? _____ años

25-26 ¿ Qué edad tiene usted? _____ años

¿ Qué parentesco hay entre usted y el principal de la familia?

27 ___
_____ 1. Soy el mismo
_____ 2. Hijo
_____ 3. Hija
_____ 4. Esposo (a)
_____ 5. Otro pariente
_____ 6. Otro

¿ Qué es su sexo?

28 _____ 1. Varón _____ 2. Hembra

¿ Cuanto tiempo ha vivido:

29-30 ¿ En este estado _____ años?
31-32 ¿ En este condado _____ años?
33-34 ¿ En esta dirección _____ años?

¿ Cuantas personas, incluyéndose usted mismo, viven con su familia?

35-36 _____ número de personas.

¿ En cual de las siguientes categorias de ingresos está su familia (el total de los ingresos de la familia antes de quitar las contribuciones de impuestos, seguro, etc., por favor incluya los ingresos de todos los miembros de la familia de dondequiera, ya séan sueldos, pensiones, asistencia del gobierno, etc.):

37
_____ 1. Menos de $1000 por año
_____ 2. $1001 - $3000
_____ 3. $3001 - $5999
_____ 4. $6000 - $8999
_____ 5. $9000 - $12,000
_____ 6. $12,001 - $15,000
_____ 7. $15,001 - $20,000
_____ 8, más de $20,000

¿ Cual es la dirección de correo de esta familia?

_____ _____
Calle o (buzón o apartado) Número de ZIP CODE

¿ Cual es la religión del principal de esta familia?

38
____ 1. Ninguna
____ 2. Católico
____ 3. Protestante
____ 4. Otra_____

¿ A cual grupo etnico pertenece el principal de esta familia?

39
____ 1. Hispano-americano, Mexicano-americano
____ 2. Indígena (Indio)
____ 3. Negro
____ 4. Anglo
____ 5. Otro _____

40-41 ¿ Qué es el máximo grado escolar que ha terminado el principal de esta familia? _____

42-43 ___ ¿ Qué es el oficio del principal de esta familia? Por favor especifique (por ejemplo, trabajador de líneas telefónicas en vez de, trabaja por la compañía de teléfonos) _____

_____

El principal de esta casa:

44
____ 1. Trabaja de por si
____ 2. Trabaja por el gobierno (federal, del estado, o local)
____ 3. Es militar
____ 4. Trabaja por una compañía privada
____ 5. Está retirado
____ 6. Otro (especifique _____ _____

45 ¿ Tiene licencia de manejar el principal de esta casa? ___1. Sí ___2. No

46 ¿ Tiene automobil el principal de esta casa? ____1. Sí ____2. No

¿ En donde usted vive, tienen los miembros de su familia entrada a:

47
____ 1. Caminos de todas temporadas, siempre alcanzadizos dentro de un cuarto de milla?
____ 2. Caminos secundarios transitables casi siempre?
____ 3. Caminos de temporada no transitables?
____ 4. Otro _____

80 5. COMENTARIOS ADICIONALES: _____

_____

_____

GRACIAS.

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